FINAL TECHNICAL REPORT

July 2000 – July 2005

HEALTH REFORM AND DECENTRALIZATION PROJECT
REDSALUD

For:
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United States Agency for International Development (USAID)
Mission in the Dominican Republic
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SO 10: Sustained Improvement in Health of Vulnerable Populations in the Dominican Republic

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List of Acronyms

Abt	Abt Associates Inc.
CBO	Community Based Organizations
CES	CES University
CERSS	Executive Commission for Health Sector Reform
CONSAD	Consultoras para el Desarrollo
COP	Chief of Party
DA	Development Associates
DIDA	Social Security Ombudsman Office
DIGECITSS	Directorate for Control of Sexually Transmitted Infections and AIDS
DPS	Provincial Health Directorates
DR	Dominican Republic
DRS	Regional Health Directorate
EPI	Expanded Program for Immunizations
EOP	End of Project
F&A	Finance and Administration
FHI	Family Health International
GODR	Government of Dominican Republic
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IADB	Inter American Development Bank
IEC	Information, education, and communications
INTEC	Instituto Tecnologico de Santo Domingo
INSALUD	Instituto Nacional de la Salud
IT	Information Technology
ME&R	Monitoring, Evaluation and Reporting
MCH	Maternal and Child Health
MIS	Management Information System
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHA	National Health Accounts
OAU	Oficina de Atencion al Usuario
PAHO	Pan American Health Organization
PHR	Partners for Health Reform
PLWA	Persons living with AIDS
PMP	Performance Management Plan
QA	Quality Assurance
SENASA	National Health Insurance Fund
SESPAS	Ministry of Health and Social Welfare, Dominican Republic
SISALRIL	Office of the Superintendent for Health and Workers' Compensation
STTA	Short-Term Technical Assistance
SIUBEN	Unified System for Identification of Social Security Beneficiaries
TA	Technical Assistance
TB	Tuberculosis
USAID	United States Agency for International Development
USG	United States Government
WB	World Bank

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Patricio Murgueytio

Executive Summary

In July of 2000, USAID signed a contract with Abt Associates Inc. to implement the Health Reform and Decentralization Project (*Reforma y Descentralización en Salud – REDSALUD*), a five-year, bilateral program designed to support the health reform process in the Dominican Republic. REDSALUD was designed to contribute to achieving Strategic Objective 10 (formerly known as SO2) "Sustainable health improvement vulnerable populations in the Dominican Republic" for the US Agency for International Development (USAID). Following a three-tiered strategy, REDSALUD implemented three technical components which operated in an integrated fashion. These technical components were (a) support to local health management strengthening and service delivery, (b) support to the central level of the Ministry of Health (*Secretaria de Estado de Salud Pública y Asistencia Social - SESPAS*) and (c) support towards building and sustaining a favorable policy environment for health reform. In addition, REDSALUD administered a grants program to support demonstration projects related to the decentralization program.

During the first year, REDSALUD focused on start-up activities, such as formation and orientation of the technical team, fine-tuning the project's objectives and technical approach, and establishing working relationships with key institutions in the public health sector. SESPAS assigned USAID the Dominican Republic's (DR) Eastern Region as the intervention site for the project, which includes 5 provinces and approximately 900,000 population. Later that year the project began implementation of the first generation of demonstration projects geared towards improving the organization, management and delivery of basic health services in 3 provinces. This was the result of a competitive process carried out in the DR's public sector for the first-time. Emphasis was on a training program of a "critical mass" of change agents to support the reform process, along with the development and use of management tools. This program benefited approximately 2,000 professionals, technical staff, and community leaders. Baseline data collection for monitoring and evaluation was done through the use of various instruments that measured the level of managerial capacity, the degree of decentralization, and user satisfaction.

During the following year, second and third generations of demonstration projects were added with focus on improving customer satisfaction and quality of care at the hospital level, as well as laying the foundation for the new health and social security system to operate in the Eastern Region. REDSALUD initiated its "Patient-Centered Service Offices" (OAU) demonstration projects in 14 hospitals in the Eastern Region. The purpose of these projects was to raise knowledge, awareness, and skills among hospital staff of the need to strengthen customer relations, patient safety, and overall quality. In addition, these projects sought to establish links between the users and the hospitals, as well as between the first and second level of care, and between hospitals and payers as required by the new legal and regulatory framework. The OAU is generation of projects developed several interventions, including setting up customer care offices; patient registration and patient record management systems; referral mechanisms; and the application of biosafety norms and standards in key services. This approach was complemented by social mobilization conducted in collaboration with the Social Security's Directorate for Information and Defense of Affiliates (*Dirección de Información y Defensa de los Afiliados – DIDA*) and the National Health Insurance Fund (*Seguro Nacional de Salud – SENASA*).

A regional demonstration project was designed to support implementation of social security. Participating agencies were SENASA, the Superintendent's Office for Health and Labor Risks (*Superintendencia de Salud y Riesgos Laborales – SISALRIL*), and DIDA. SENASA played a particularly important role as purchaser of family health care services for the subsidized regime. This became one of the most salient changes in the new system that seeks to improve vertical equity in the Dominican health care system. Technical assistance provided to SENASA addressed selection and enrollment of beneficiaries; contracting; provider payment mechanisms; auditing; and information systems.

The third year of the project marked a period of consolidation and expansion of the technical activities, in addition to initiating a systematic process of documentation of the work being carried out. In this period REDSALUD continued and expanded the implementation of demonstration projects in the Eastern Region. During this period, "hospital management strengthening" demonstration projects were initiated in the 14 hospitals through 7 new grant agreements. The purpose of these projects was to improve managerial aspects of hospitals, including the definition of a service portfolio, costing, and prospective budgeting. The aim was to enhance efficiency and accountability among these organizations.

During the fourth year of implementation REDSALUD continued activities underway in the previous years. Further consolidation and expansion was achieved, despite a difficult environment due to a heavily charged political context and economic crisis in the government sector. This produced very difficult conditions for project implementation, which were reflected in performance indicators. Year four ended with the transition to a new administration in the Dominican government (GODR). The fifth year of the project was a wrap up year, where most of the initiatives were consolidated or contemplated for follow-on under a new contract. This was in fact the case as Abt Associates Inc. was awarded the two-year follow-on contract for REDSALUD II until 2007.

Among the most important results of REDSALUD has been strengthening of the management culture among health personnel of SESPAS service delivery organizations involved in all demonstration projects. This new culture manifested itself by the adoption of management systems and practices that have begun to produce tangible results. This was complemented by progress in the area of community participation and mobilization through a number of strategies and activities. The latter's purpose was to improve the odds for sustainability by developing citizen ownership over changes occurred.

Despite false starts of the social security system in the Eastern Region until the time this report is written, SESPAS providers experienced significant capacity building and managerial strengthening as a result of REDSALUD interventions. SENASA, the public health insurance agency, is expected to play a pivotal role as agent of the community, particularly the voiceless poor, in the context of improving access and utilization of public health care services.

Throughout the life of the project REDSALUD continued to support the central MOH level, in particular various national health directorates with interest in broadening their understanding of implications of reforms on their operations. Other areas were less responsive due to institutional inertia and difficult-to-change centralized and clientelist practices. The electoral cycle offered a keen opportunity to develop intense policy dialogue and advocacy activities to promote the health reform agenda among political parties.

Upon the conclusion of REDSALUD many concrete results are part of the project's legacy. Over 15 management tools were developed. Key performance indicators experienced modest improvements in the desired direction, despite a very adverse environment. More importantly, work carried out in the Eastern Region was observed with a great deal of interest by other regions and health sector institutions. This creates a favorable environment for consolidation and scaling up, goals which USAID is committed to supporting in the near future. Although health and development are still elusive concepts in the Dominican Republic, the REDSALUD project demonstrated that it is possible to carry out change putting people first.

I. Background

The USAID Contract

The United States Agency for International Development (USAID), mission to the Dominican Republic, signed a contract with Abt Associates Inc. for the implementation of the Health Reform and Decentralization Project (Reforma y Descentralizacion en Salud - REDSALUD) during the period 2000-2005. This program was implemented in the context of bilateral cooperation agreements signed between the governments of the Dominican Republic and the United States.

The Mission's request for proposal presented the following problem statement:

> "A key reason for the relatively poor health status of the population is inadequate access to quality basic health services. In turn, a key constraint impeding expanded access to quality health care services by poor people is the lack of preventive and primary care prioritization and excessive centralization of resources and services. This constraint is a result of typical institutional weaknesses in the country. SESPAS is the main authority in the Dominican health system. However, its historically weak institutional capacity, coupled with its excessive centralization, severely limits its ability to oversee the overall health system and to prioritize customized approaches to deal with the distinct health needs in different communities. Under its current structure, there is no effective functional separation of the *purchasing* and the *provision* functions within the sector. This requires SESPAS to focus mainly on managing its own health service delivery network, at the expense of effective coordination of public-private efforts to maximize the health status of the population."

The Mission further stated that,

> …"excessive centralization and the demands of managing its own health service provision network encourage curative medicine and complex hospitals. Lack of local level participation in establishing health priorities reduce the effectiveness of priority health programs at the primary care level. Most resource allocation and budget execution is done from the capital and favors hospitals. Local level entities are bypassed, partly because they lack the capacity to strongly influence the resource allocation process. In addition, there is almost no formal interaction between the public and the private sector, although SESPAS finances some NGO health activities. The public sector purchases only three percent of its total spending from private institutions - essentially private insurance coverage for public sector employees, such as teachers and doctors. In a country where 60 percent of all ambulatory health services and over 40 percent of all inpatient services are provided by the private sector, private and public collaboration, if efficiently set up, could allow for a rapid expansion of coverage for preventive and primary care services without the need for significant additional investments. However, to do so, there is an urgent need for local level institutions to be able to identify specific areas and actions for collaboration and to increase SESPAS local capacity to establish formal linkages with private sector organizations to expand access to quality services."

Finally, USAID indicated that,

> …"there is also an urgent need to increase the role of the local SESPAS level in taking responsibility for financing and providing basic health care services and for creating incentives for the population to increase demand for them. Increasing local level SESPAS responsibility and public demand for services not only would make the implementation of

> basic health care programs more efficient (taking advantage of specific niches where small interventions could get significant results) but also would diversify the risk of depending only on the political willingness of SESPAS at the central level to prioritize these programs. Thus, the public health sector needs to undertake urgent structural reforms, particularly in the areas of decentralization and public-private integration, in order to improve the effectiveness of public expenditures in preventive and primary care at the local level. Unfortunately, although the Government is taking decisive steps towards reforming the sector, consensus building has proven to be difficult and the discussion appears to be restricted to inside the government. This reduces the likelihood that civil society demand and support for reform will ensure sustainability. Hence, it is important to encourage debate among non-governmental actors, both to increase the demand for structural reform and its sustainability across the political spectrum and to elevate and enrich the quality of initiatives and approaches to implement such reforms. This becomes more critical as the country faces a change in Government."

This statement of the problem in 1999 was visionary. It denoted a good understanding of the context at the time, as well as the challenges and opportunities for bilateral cooperation in support of the Dominican public health sector after a long period in which USAID had worked mostly with non-govermental organizations. This problem statement represented a shift towards strengthening long-neglected government services, in order to contribute to improving health care services for the majority of the population.

The contract established the following requirements.

> "The Contractor will provide services to carry out health reform activities, to complement other health related activities being carried out by other partners, to attain the Objective. The focus of the Contractor's efforts will be directed to attain Intermediate Result No. 4 (Increased efficiency and equity of basic health services, especially at decentralized levels) and for some of the expected results under IR 1 (Increased Access to HIV/AIDS/STI Prevention and Care Services by At-risk and Affected Population Groups). However, given the overarching influence of the types of sector-wide activities described in this SOW, the contractor is expected to contribute to the results under IRs 2, and 3, as indicated below.
>
> Specifically, the Contractor will contribute to the attainment of the overall strategic objective: Increased Use of Sustainable Basic Health Services and Practices (which should be viewed as a goal towards which all USAID efforts are contributing in the DR) and will be primarily responsible for achieving IR 4; and directly contributing to IR 1, along with other USAID partners…, which are the emphasis of this RFP. The Contractor is encouraged to implement the additional indicators and modifications to current indicators for these two IRs as provided in its technical approach. The Contractor will be responsible for achieving IR 4 and directly contributing to IR 1."

To this end USAID established a set of indicators to assess progress towards these results. As indicated above, language in this contract reflected a refreshing reading of the Dominican situation, which required innovative approaches and solutions. Such solutions were to come through the new legal and regulatory framework approved in 2001 and the strategies and activities implemented by the REDSALUD project. This required that USAID keep a flexible and supportive stance in order to maintain the relevance and appropriateness of the project in the context of a changing environment.

A brief overview of the Dominican health care system and the reform agenda

The Dominican health care system is in reality a "non-system" comprised of several entities, both public and private, following the organizational patterns in many less developed countries. The public sector includes mainly the Ministry of Health (*Secretaria de Estado de Salud y Asistencia Social - SESPAS*), the Dominican Institute for Social Security (*Instituto Dominicano de Seguros Sociales - IDSS*), and the military health care subsystem. The private sector includes an array of hospitals, doctor's offices, pharmacies, and laboratories. The health sector also includes approximately 200 non-governmental organizations that receive government subsidies. In 1999 there were 5.5 beds per 1,000 population and 19 physicians per 10,000 population.[1] Both figures were higher than the average for the Latin American and Caribbean region. Health financing is done through general government transfers to SESPAS to pay for infrastructure, salaries, commodities, and equipment at the central level. Salaries represent more than 80% of SESPAS expenditures. Public hospitals and district health offices (in charge of primary care services) receive a small budget allowance to cover incidental expenses. User fees are common in SESPAS facilities. IDSS is financed by means of employer, employee, and government contributions and in 2000 covered about 7% of the total population. Private sector providers are basically funded by private, pre-paid health insurance schemes known as "*igualas*" that provide coverage to no more than 12% of the population. In general, based on 1996 National Health Accounts data, health expenditures were approximately 6.3% of the gross domestic product, with 31% public and 69% private expenditures. Of all expenditures over 70% were for pharmaceuticals. Until 2001 the majority of Dominicans had no or limited health insurance coverage.

Key issues affecting the Dominican health care "system" have historically been limited access, poor quality, inefficiency, and inequity. A number of reports have documented in extenso many of the problems mentioned (see, for example, Rathe, 2000 [2] and La Forgia et al, 2004[3]). Consequently, since 1990 the country began discussing the need for health reforms that would improve the organization, operation, and financing of the health care system, particularly of government-run services. It took approximately 10 years to reach the necessary level of consensus to approve a new legal and regulatory framework, the first step in the implementation of needed changes. Evidence has shown, however, that laws and regulations were not sufficient to carry out change. Since approval of the new laws in 2001 the Dominican Republic has been unable to put them fully in practice, due to a combination of external and internal factors that have conspired against the implementation of health and social security reforms as envisioned in the laws.

With the investiture of President Leonel Fernandez in 1996 the government implemented several key initiatives to promote reforms, including the establishment of the Executive Commission for Health Sector Reform (*Comision Ejecutiva para la Reforma del Sector Salud – CERSS*) and the enlistment of significant multilateral and bilateral financial support. [4] In 1997 USAID began offering technical assistance through the centrally-funded *Partnerships for Health Reform project* (PHR), managed by Abt Associates Inc. A resident advisor was fielded in 1999 to work on strengthening a small group of Provincial Health Directorates (*Direcciones Provinciales de Salud – DPS*) and on developing a framework for monitoring and evaluation of the health reform process. In the meantime USAID completed country assessments and prepared terms of reference for a request for proposal (RFP) for a bilateral project in support of health reform.

1 Pan American Health Organization (2001) Dominican Republic – Country Profile.

2 Rathe M (2000) Health and Equity: A perspective into health financing in the Dominican Republic (in Spanish). Macro International, Santo Domingo.

3 LaForgia G, Levine R, Diaz A, and Rathe M (2004) Fend for yourself: systemic failure in the Dominican health care system. Health Policy (67): 173-186.

4 In 2000 the DR had nearly $120 million in bilateral and multilateral financing in support of health reform.

After a lengthy evaluation process USAID announced that the proposal submitted by Abt Associates Inc. had been accepted. The Mission thus awarded a contract for implementation of a five-year program, the Health Reform and Decentralization project (*Proyecto de Reforma y Descentralizacion en Salud – REDSALUD*). A contract was signed on July 20, 2000, as the first Fernandez administration waned. On August 16, 2000, the administration of President Hipolito Mejia (2000-2004) took office on behalf of the *Partido Revolucionario Dominicano* (PRD) party. As is traditional in the Dominican political culture, the new government replaced most incumbents with new and often inexperienced appointees whose merits rested more on political rather than technical qualifications. These changes, often dreaded by the donor community, brought on a new cast of characters to the Ministry of Health and other key health sector institutions. New government officials were not aware of the content and scope of the new USAID project. In fact, REDSALUD was received with a high level of skepticism and doubts. Some in the new administration believed that the project's purpose was to "privatize" the public health sector in continuation of the previous government's agenda. Both of these wrong perceptions affected a smooth project start up. Even USAID leadership was concerned about the relevance of the new project in view of the limited interest and commitment by local stakeholders in support of health reform. Despite this adverse environment a formal project start-up event took place in September of 2000. The field implementation team was assembled soon thereafter, and an office site was selected. The new project finally lauched field operations in early 2001, as the Mejia administration worked to delineate its formal government program, which underscored health and social security as priority areas.

In the meantime the Congress continued to debate drafts of two new laws, the health law and the social security law, in the midst of significant opposition from the *Dominican Medical Association (AMD)*. The social security law was especially targeted by the medical syndicate as a threat to physician employment in the government sector and a potential effect on controlling physician fees in the private sector. It was only after the introduction of several changes in the social security law and intense last-minute lobbying by CERSS that both laws, Health Law 42-01 and Social Security Law 87-01, were approved by the Dominican congress between April and May of 2001. Although a comparative analysis of both laws is beyond the scope of this technical report, it is important to recognize some important differences and even contradictions between them. The table below summarizes key aspects of each law.

Table 1. Comparative analysis of Laws 42-01 and 87-01, Dominican Republic

Key Aspects	Health Law 42-01	Social Security Law 87-01
General Purpose	To strengthen SESPAS's steering and health authority role by updating the 1956 Health Code (Codigo Trujillo)	To establish a new social security system responsible for providing health insurance, retirement benefits, and workers' compensation
Main features	• Establish national health system • Update sanitary codes • Decentralize SESPAS functions and responsibilities	• Mandatory social insurance with universal coverage • Introduces demand-side financing in health care • Quasi-internal market for public health care providers (purchaser-provider split) • Competitive market for private insurers and service providers
Responsible Organizations	• National Health Council • Central level SESPAS • District Health Offices	• National Social Security Council • SS Manager's Office • Treasury for Social Security • Superindent's Office for Health and Labor Risks • Superintendent's Office for Pensions • SS Ombudman's Office • Health Risk Management Organizations • Autonomous Service Providers

The new model for the development of the health care system in the Dominican Republic is known as "managed competition," because it combines aspects of a competitive market with a strong regulatory function by the state. This model introduced a series of innovations in the organization, management, monitoring and control, and financing of the Dominican health system, implemented through strategies such as separation of functions, mandatory demand-side financing based on prospective budgeting and productivity; accountability, and user choice. The reforms outlined by Law 87-01 required the organization and development of various new institutions in order to carry out mandates in the law. Among these institutions, the National Social Security Council (CNSS) and the National Health Council (CNS) were created to support the new system's stewardship and governance functions. These councils expressed the notion of "shared stewardship" where key stakeholders participate in policy setting and oversight, including the government, corporate sector, working class sector, and civil society representatives. This mechanism was designed to strengthen opportunities for dialogue, consensus building, and sustainability of important policy/strategic decisions about the new health and social security system.

From the perspective of USAID objectives, two key elements are worth noticing in this new scenario. Law 87-01 established the National Health Insurance Fund (*Seguro Nacional de Salud – SENASA*) as the public health risk management organization. This agency was, and is, responsible for receiving and managing government subsidies to provide coverage for the poor and the chronically disabled. This was a significant departure in the history of the DR's health system. For the first time there was a deliberate decision to address to health needs of the most vulnerable population groups, thus creating conditions to improve equity in access and use of health care services. Another important change was the law's mandate to turn service providers into autonomous public entities that is separate from SESPAS' direct central level control. This constituted a step towards effective decentralization that was intended to alter provider institutional behavior, seeking greater efficiency, effectiveness, and responsiveness.

The context for reforms was not free of difficulties, however. Some important obstacles to keep in mind were and remain:

(a) The absence of a "critical path" for reform, and weaknesses in national leadership and local technical capability.
(b) Limited allocation of resources to support the new system.
(c) Slow understanding and acceptance of the new paradigm and of the resulting changes in institutional culture and practices.
(d) Conflicts and contradictions among key institutional players and interest groups (such as the physician syndicate) that affect the establishment of the health and social security system.

In conclusion, the REDSALUD project was designed to respond to a changing scenario in the evolution of the Dominican health care system. Several important circumstances coincided and shaped the content and scope of the project: a new set of laws, social demands for change, political will (albeit erratic), and donor commitment. The challenge was to maintain conceptual coherence and technical competence in order to meet USAID expectations and, overall, to become a point of reference in an otherwise confusing process.

II. Project Purpose and Objectives

The primary purpose of the project was to contribute to the achievement of USAID's Strategic Objective 10 (SO10), "sustained improvement in the health of vulnerable populations in the Dominican Republic." In addition, REDSALUD was designed to contribute directly to the achievement of Intermediate Results 10.4: "to promote efficiency and equity of basic health services at the local level;" and 10.1, "to increase use of HIV/AIDS services and prevention." The project was intended also to contribute indirectly to accomplishing Intermediate Results 10.2 and 10.3: "To promote sustainable and effective reproductive

health and family planning services by the public and private sectors" and "to increase use and effectiveness of selected child survival services", respectively.

In addition to USAID's objectives, REDSALUD sought to support host government objectives to implement a health reform process as defined by laws 42-01 and 87-01 (health and social security, respectively). During the 2000-2004 administration, during which most of the project's activities were implemented, REDSALUD aimed at contributing to the government's stated goal of poverty reduction by strengthening the Ministry of Health's service delivery and the new social security financing systems.

The project's results framework (2001 version) is provided in Annex 1. The revised results framework (2002-2007 USAID strategy) is included in Annex 2.

III. Project Implementation

1.0 Project Organization and Management

REDSALUD was a project funded by the US Agency for International Development, mission in the Dominican Republic. The name REDSALUD is a Spanish acronym for "Reforma y Descentralización en Salud" (Health Reform and Decentralization). This name also implied the notion of "health networks" (*redes de salud*), a concept that became one of the project's guiding strategies. As part of a bilateral cooperation program the project's management was responsibility of the country team, supported by Abt's home office in the US. In addition, the project received able and timely support and oversight by USAID staff in the Office of Health and Population, as well as in other programmatic, financial, and contract management offices in the DR Mission. To this extent, REDSALUD's achievements must be credited to this group of individuals committed with the project's objectives and, ultimately, the well-being of the Dominican population.

REDSALUD was implemented by a technical team led by Abt Associates Inc, a US-based consulting firm with over 40 years of experience in international health and general development programs. Other US-based partners included Development Associates, Family Health International (FHI), and American Manufacturer's Export Group (AMEG). Dominican partners included Instituto Nacional de la Salud (INSALUD) and Instituto Tecnologico de Santo Domingo (INTEC). George Washington University, Consultoras Asociadas para el Desarrollo (CONSAD), Center for Demographic Studies (CESDEM), and CES University (Medellín, Colombia) participated as collaborating partners. All subcontractors and collaborators generally fulfilled their roles and responsibilities to full satisfaction. They provided valuable technical support to the field team and to counterparts. They were well integrated into project strategies and activities turning the project into a seamless operation.

The project's organizational chart at the end of the project is presented in Annex 3.

2.0 Technical Implementation Strategies

The technical implementation of REDSALUD rested on the principles of:

- Forging strategic alliances/partnerships
- Promoting the sustainability of reforms
- Dominican solutions for Dominican health reform
- Learning by Doing
- Flexibility

REDSALUD's vision as presented in the proposal to USAID in early 2000 was "…to increase the use of sustainable basic health services, and to implement effective HIV/AIDS prevention and care programs at

the local level in the Dominican Republic…" Furthermore, we proposed "to use USAID funds to stimulate the development of local level, integrated health service networks, consisting of both public and private providers – including primary health care and HIV/AIDS prevention and care -- to increase the provision of quality health services to the poor and other consumers." These networks would provide "bottom-up" impetus to leverage changes in resource allocation and to further the decentralization process. We would also "work with, and provide assistance to, central SESPAS and the local health directorates (direcciones provinciales o municipales de salud - DPS/DMS) as they assumed their changing and expanding roles as the managers, regulators, purchasers, and evaluators of health services; and a supportive policy environment will be fostered at national, provincial, and local levels."

The results proposed in the REDSALUD contract were:

- Increased availability of affordable, integrated basic health services (including HIV/AIDS/STI) in 14 DPS/DMS;
- Improved monitoring and assurance of quality of basic health services in 14 DPS/DMS; and
- Improved targeting of public and private health expenditures to preventive and primary health care services in 14 DPS/DMS.

We stated, "…these results will lead directly to the project goal of improved provision of, and resource allocation for, affordable, quality, basic health services in the Dominican Republic." We also indicated that to realize this vision, our team would implement three strategies:

- *Strategy 1: Implement and evaluate innovative health service networks to deliver affordable, quality, basic health care services (including HIV/AIDS/STI prevention and care) in 14 DPS/DMS.*
- *Strategy 2: Strengthen SESPAS' capacity to manage and regulate, and to allocate resources, for the decentralized provision of affordable, quality, basic health care services.*
- *Strategy 3: Develop a policy environment that supports health sector reform at national, provincial, and local levels.*

Strategy 1 was slightly modified in the course of project implementation. The main focus remained on the establishement of provider networks at the local level, including HIV/AIDS prevention and care, but only in one region of the country (Eastern Region, including 5 provinces). Strategies 2 and 3 remained basically the same throughout the implementation period. The rationale for changing Strategy 1 is discussed in the following section.

Strategy 1. Strengthening of Local Health Care Management Capacity: Design and Implementation of Demonstration Projects.

This component was initially known as the "decentralization" component. This name was modified slightly to better communicate the purpose of this strategy to government counterparts biased by the project's design during the Fernández administration and their own limited understanding of the issues. The main goal for this component was to contribute to strengthening local management capacity among health care organizations in preparation for the new health and social security system. The project team envisioned that greater levels of autonomy would be necessary among health care organizations in the reformed system, thus the need to implement capacity building strategies and activities geared towards the development of effective and efficient management practices.

To this end, SESPAS initially assigned to USAID in March 2001 Regions "0" and "V" for project implementation. This decision sought to target project resources and to maximize impact in a specific geographic area, as opposed to working in 14 provincial health directorates as originally proposed for

Strategy 1. This was a sound decision in hindsight, particularly since SESPAS, CERSS, and several international cooperation teams had de-facto split up the country in several regions. For example, with World Bank support CERSS implemented the *Provincial Health Systems* project in the Southern Region. CERSS also implemented the *Reform and Modernization of the Health Sector project* at the central SESPAS level as well as in the Southwest, Central-West, and Central (Cibao) regions, with support by the Inter American Development Bank. The European Union implemented the PROSISA project in the Northeastern region. The Pan American Health Organization provided technical assistance in the South as well.

REDSALUD began to work in Region V or the Eastern Region, which included the provinces of La Altagracia, San Pedro de Macoris, La Romana, El Seibo, and Hato Mayor, with a population of approximately 900,000. Region 0, which included Areas III and IV in the city of Santo Domingo and the province of Monteplata, was later dropped as a project intervention site due to the need to concentrate efforts in one region only. This allowed for well-targeted interventions particularly as the reform process demanded greater technical effort and financial resources. In order to speed up technical and operational consolidation and standardization within the technical team, internal information dissemination and training efforts over topics such as health care organization, health management, health economics, financing, and health care reform, among others, were initially conducted. This allowed for the analysis and discussion of topics relevant to the Dominican reform process. Support by Abt home office staff and consultants contributed to this effort.

The work of this component faced some obstacles, which were largely overcome by the team's greater understanding of the issues, appropriate technical guidance, and overall support by the whole technical team. The start-up of field activities also contributed to improving team performance. In addition, integration with the other technical components, i.e. SESPAS support and policy support, improved as the team gained insight and experience.

The main technical approach to implement Strategy 1 was by designing and putting in practice a series of demonstration projects in the Eastern Region, in a staggered fashion (i.e. in several "generations" of demonstration projects). The sequence was to focus first on **priority health services** provided at the primary care level. The first generation of demonstration projects was thus related to strengthening the delivery of vaccination services and of prevention and control of diarrheal disease in three provinces, with the provincial health directorates as focal points. The second generation of demonstration projects sought to intervene at the hospital level by means of establishing **customer care offices** (O*ficinas de Atención al Usuario*), which were in fact a comprehensive quality improvement strategy. The third generation of demonstration projects also focused on improving **hospital management** skills and practices. The fourth generation of demonstration projects had a regional scope and supported the organization and operation of several offices responsible for the implementation of the **new social security law**, such as SENASA, SISALRIL, and DIDA. A total of **17 demonstration projects** were designed and implemented during the 2000-2005 period. Funding for the demonstration projects was provided by USAID through a pass-through grants program that was part of the REDSALUD design. Under this program USAID provided funds as new demonstration projects were designed and formal agreements were reached between the contractor, Abt Associates, and beneficiary organizations (i.e. DPS, hospitals, or social security entities). Abt was a trustee of the grants fund, but also provided technical assistance and monitored implementation of each demonstration project. This required a specialized grants management team in order to adequately follow USAID requirements and regulations. These generations of demonstration projects are described in greater detail in the following sections.

First Generation Demonstration Projects: Strengthening of Basic Health Services

The purpose of the first generation demonstration projects was to strengthen the delivery of basic health care services under the responsibility of provincial health directorates or *Direcciones Provinciales de*

Salud (DPS) in the Eastern Region. The working hypothesis was that by strengthening selected services in terms of improved management practices and tools and by training of human resources, targeted services would improve overall performance, including quality and efficiency. Furthermore, the project team believed that other services in the DPS portfolio would be positively influenced by measurable progress achieved among targeted services. In addition, the team expected that successful implementation of these projects would lead to improvements at the regional level as part of scaling-up effect, beyond the immediate demonstration site efect. The decision to focus on basic services was based on (1) the need to focus on tangible, discrete issues that could yield results in a short period of time; (2) the need to improve the delivery of priority, high-demand services at the local level, and (3) the uncertainty of the health reform process at the time (i.e. laws under discussion in the Congress).

The general approach consisted of inviting all five DPS in the Eastern Region to submit proposals to address a priority health problem as defined by each DPS team. To this end they conducted rapid assessments and determined which problems required quick intervention with REDSALUD support. As background, it is important to remember that an outbreak of measles swept the Dominican Republic between 2000-2001, with an important number of cases reported in the Eastern Region. Diarrheal disease and other waterborne illnesses were frequent problems in El Seibo due to the lack of appropriate safe water and sewage systems, as well as poor hygiene practices and solid waste management. Other significant problems were elevated maternal mortality, domestic violence, and HIV/AIDS. Each DPS was asked to present 2 written proposals, whose formulation required technical assistance from the project team. These proposals, 8 in total, underwent a competitive evaluation. This was the first time that SESPAS units participated in a competitive process which was by itself an accomplishment. Eight proposals were evaluated and three were selected, as follows: Hato Mayor DPS and La Romana DPS, each focused on **strengthening of vaccination services**; and El Seibo DPS focused on **control and prevention of diarrheal disease**. As mentioned, funding to implement each demonstration project was made available by USAID, with a 25% cost-sharing, in-kind contribution by the partner organizations (i.e. DPS). This contribution included salaries of personnel involved, facility use, use of equipment, transportation, etc.

During Year 4 of the project, in late 2004, the Dominican Republic was hit by Hurricane Jeanne. This storm affected the northeastern regions of the country, particularly the Eastern Region where REDSALUD implemented demonstration projects. The storm caused significant damage to the road infrastructure due to sudden flooding that destroyed several bridges. It also knocked down communications and power supply installations, and damaged water and sewage systems. Although fortunately only a few deaths were registered, there were important material losses in several communities. The municipality of Ramon Santana, for example, was totally flooded and remained inaccessible for several days. The province of La Altagracia was also inaccessible for weeks. This natural disaster challenged the readiness of all DPS in the Eastern Region and required that USAID redirect some resources to the affected areas. This was an opportunity for the REDSALUD team to put together a **management strengthening intervention in case of natural disasters**, which was included in this generation of demonstration projects.

Table 2 below summarizes the most important technical aspects and results from each of these first demonstration projects sponsored by the USAID grants program and managed by REDSALUD/Abt Associates.

Table 2. Strengthening of Basic Health Services in the Eastern Region of the Dominican Republic, 2000-2005

Name of Project	Location and key characteristics	Main Strategies	Key Results
Strengthening of fixed vaccination sites for the Expanded Program for Immunizations – EPI	**La Romana** ▪ 223,000 pop (est. 2001) ▪ Two municipalities ▪ Targets children under 5 and women in reproductive age.	▪ Three-stage process (Los Mulos health center; Villaverde, Guaymate, IDSS Clinic; F.Gonzalvo Hospital, Suarez Clinic) ▪ Improve management capacity of EPI services. ▪ Improve access to EPI services. ▪ Improve efficiency in EPI resource use. ▪ Improve quality of EPI services. ▪ Social Mobilization.	Three community support groups established. 75 SESPAS staff trained
Strengthening of vaccination services (Expanded Program for Immunizations – EPI)	**Hato Mayor** ▪ 90,000 pop (est. 2001) ▪ Three municipalities ▪ 70% poverty rate	▪ Alliance DPS-Adoplafam (local health development NGO) ▪ Strengthen planning, supervision of EPI services ▪ Improve quality of EPI services. ▪ Strengthen EPI-related logistics system. ▪ Develop a social recognition and rewards system. ▪ Promote social participation as a sustainability strategy. ▪ Monitoring and evaluation.	Ten community support groups established. 60 SESPAS staff trained
Scaled-up, regional outputs in support of EPI	**All Eastern Region provinces** ▪ Est. population 900,000 (2003). ▪ 40% under 15 years of age.	▪ Regional EPI support group. ▪ Effective collaboration among regional entities and projects. ▪ Immunization clinic licensure and accreditation. ▪ Improved cold chain. ▪ Induction of demand for vaccination services. ▪ Overall improvement in vaccination coverage.	▪ Regional EPI management support group established. ▪ 150 staff trained ▪ Fixed / mobile vaccination clinics established: La Altagracia…….8 / 5 Hato Mayor……...6 / 20 El Seibo……....8 / 8 La Romana……...5 / 0 SPMacoris.……..26 / 14 Total ……...53 / 47
Effective Management of the Treatment of Acute Diarrheal Diseases (ADD) in the Province of El Seibo	**El Seibo** ▪ 97,000 pop (est. 2001) ▪ Two municipalities ▪ 70% unemployment rate. ▪ Third poorest province in the DR.	▪ Human resource management ▪ Information systems ▪ Logistics management ▪ Inter-sectoral integration ▪ Monitoring and evaluation plan ▪ Public recognition of management capacity	▪ 17 community oral rehydration units (UROs) established and furnished. ▪ 200 individuals trained ▪ Proportion of childhood ADD cases managed through UROs: 2002……..31% 2003……..42% 2004……..72% ▪ ADD prevention educational materials developed. ▪ IEC strategy updated and implemented. ▪ 11 support groups established ▪ Community empowered to channel demands for better public services.
Emergency management and mitigation of health risks among vulnerable populations in case of natural disasters.	**Eastern Region** ▪ Duration 3 months	▪ Training in emergency needs assessment and response planning. ▪ Logistics management of critical supplies. ▪ Health education. ▪ Coordination.	▪ Procurement and distribution of emergency supplies ▪ 60 MOH staff trained

Tools developed

Three management tools were developed to support implementation of these first-generation demonstration projects. The first was an **"individual vaccination registry"** (*Registro Individual de Vacunas – RIV*), which was an electronic database for immunization clinic clients. The purpose of this computer-based tool was to facilitate collection and management of vaccination data in the facility's catchment area. Specifically, this tool assisted in the identification of unvaccinated children, projected expected service demand and resources needed, calculated coverage rates, and prepared technical reports. This system replaced the old practice of handing out cards with the individual's vaccination history, which were often lost or misplaced by mothers or guardians. The loss of vaccination cards often led providers to (a) not know the immunization status of individuals, and/or (b) administer vaccines without a clear medical indication or to be on the "safe side" given the lack of information. It must be noted that this application is part of a modular health information system being developed for the Eastern Region as part of preparations for the new social security system. The RIV module may be linked to other modules developed uner the customer care or hospital management strengthening demonstration projects.

The second was a **vaccination monitoring graph**, adapted from the Pan American Health Organization. This graph enabled the recognition of specific vaccination goals in a given catchment area, based on population at risk and productivity. It allowed for the calculation and depiction of vaccination coverage rates against clear program goals at any point in time, so that managers would assess their effectiveness in reaching the said goals.

The third tool developed was a **computer-based application for inventory control and logistics management of critical supplies** for the EPI program. This tool was designed by REDSALUD staff in collaboration with colleagues from the CONECTA project. The purpose was to keep track of stocks of vaccine and other necessary supplies in order to monitor availability or place reorders of needed inputs thus facilitating successful program management and service delivery. This tool is versatile and may be adapted to other purposes.

The fourth management tool was an **electronic database to collect and manage data related to acute diarrheal illness** (ADD) in El Seibo province. During this period, the software for outpatient use of oral re-hydration was designed and implemented with ADD patients, and is currently in the process of being tested in the Hospital Municipal of Miches, pending its later installation in the remaining Oral Re-hydration Units.

Second Generation Demonstration Projects: Developing Customer Care Offices and Quality Improvement in SESPAS Hospitals of the Eastern Region.

First generation demonstration projects focused on improving DPS and health center capacity to deliver basic services in the Eastern Region. The second generation demonstration projects focused on hospitals as the core institutions for targeted reform efforts, given their important operational and symbolic role in the Dominican health care system. Hospitals generally concentrate most of health expenditures and represent the "face" of the government's response to people's health needs and concerns. In the context of reform, it was important to introduce the concept of "customer care" in order to prepare hospitals for autonomy and financial survival in a quasi-competitive environment. The new social security law in the DR establishes that public hospitals shall become independent institutions, separate from the central ownership of SESPAS (although politically linked to it), with their own assets, equipment, and human resources. Furthermore, the law envisions that SENASA should organize provider networks based on criteria of accessibility and cost-efficiency, where hospitals are required to operate on the same principles. This new *purchaser-provider split* creates a quasi-competitive environment for public hospitals. In addition, it underscores the need to promote customer satisfaction and customer loyalty as, under the new health demand-based health financing scheme, provider payment is linked to effective service delivery

and user satisfaction. In addition, it was necessary to improve patient flow (i.e. referrals) in order to lay the foundations for a provider network to operate effectively and efficiently. Thus it was important for hospitals to understand that without customer satisfaction strategies, the purchaser (SENASA) or the patient-clients could potentially choose other providers and channel resources to them instead of to non-responsive providers.

Upon this new scenario REDSALUD considered it critical to develop interventions geared to changing the culture of providers in favor of greater awareness and practical skills to enhance customer care, patient flow, and satisfaction. The team invited all 14 hospitals in the Eastern Region to submit competitive proposals to organize and implement "customer care offices" (*Oficinas de Atencion al Usuario – OAUs*) as the tangible expression of this important change. Twelve hospitals submitted proposals and 11 were accepted. All proposals received technical assistance for their full formulation. Hospitals were then grouped into 7 demonstration projects which comprised the new batch or generation of projects. They started formally in July of 2003 for an approximate duration of two years each (Annex 5).

The **general objective** for each of these projects was to "organize the hospital so that it employs the best practices in management and service provision required to succeed in the new environment by offering high quality services and ensuring patient satisfaction."

The specific objectives included the following:

- Through an ongoing training program, develop the necessary skills and capacity to improve patient care.
- Implement IEC strategies to improve patient care.
- Establish a basic information network to support project activities and ensure timely decision-making.
- Implement a referral system that ensures adequate articulation between primary, secondary and tertiary care that guarantees integrated service provision to patients.
- Promote patient participation and information about services offered via existing community organizations and coordination with the DPS and DIDA.
- Develop monitoring and evaluation methods that provide ongoing feedback to measure project's progress concerning management and quality.
- Recognize those employees or staff members that have outstanding participation in improving the quality of the services.

Accordingly, the proposed technical approach included the following key activities:

- Training
- Information, Education and Communication
- Patient Information Network
- Referral System
- Community Participation
- Monitoring and Evaluation
- Incentives Program

In practice, each of these demonstration projects comprised the following stages:

- First stage: set up the infrastructure, equipment, and personnel for customer care offices.
- Second stage: carry out a quality improvement process by promoting biosafety knowledge and practices for internal and external clients.
- Third stage: improve patient flow mechanisms (medical records management, referrals, and appointments).
- Fourth stage: social mobilization and participation.

The **first stage** required the design of a physical setting for each OAU, including its placement within the hospital's public access area, minor renovations, signage, and the provision of furniture and equipment. To this end project staff worked closely with hospital representatives to decide on each of these operational details. Hospital directors established a regional working group to provide needed leadership and carry out these projects in a coordinated and effective fashion. As a means to encourage and motivate hospital staff, for example, the project carried out a competition to improve the areas surrounding each hospital. This led all hospitals to collect trash, clean gardens, and mend fences. This resulted in more attractive facilities where customers would feel welcome and safe. An importat aspect was the deployment of suggestion boxes and the establishement of joint hospital staff-community committees to discuss user comments and make decisions to address specific complaints. All OAUs received basic furniture and computer equipment to operate. OAU staff were selected from existing hospital personnel and trained on hospitality and communications skills. REDSALUD designed an electronic patient registration tool that was installed in all OAUs and served to collect basic patient information and to generate a summary sheet of each encounter, including service use and cost data for invoicing purposes. The patient registration database was linked to the national voter registration database in order to facilitate the correct identification of each user. This tool was also designed to verify enrollment status by SENASA and potentially by any other insurance carrier. Once the SENASA enrollment database is ready, it will be used to verify user eligibility for services. This way, OAUs are envisioned to serve as the links between customers and hospitals, between hospitals and referral facilities, and between hospitals and payers.

The **second stage** consisted of a quality improvement strategy focusing on internal and external client safety. This was an important element of customer care that took into consideration not only patients but also hospital personnel. This component entailed the involvement of an international consultant and local consultants to assist in the completion of a situation analysis; the formulation and implementation of an action plan to improve biosafety and hospital waste management, including procurement of select equipment and supplies; and follow up. To this end, several key areas were included for interventions, such as emergency services, surgical wards, labor and delivery rooms, and sterilization services in all 14 hospitals of the region. By adopting this **biosafety improvement** approach REDSALUD sought to raise awareness among health care personnel about the need to follow preventive measures to reduce work-related risks produced by biological, physical, or chemical agents in the hospital setting. The overall purpose was to improve general conditions in all hospitals in the Eastern Region.
The specific objectives for this intervention were:

- To raise awareness among hospital staff to participate in a continuous quality improvement process in service delivery.
- To develop a training plan to enhance knowledge and skills to promote self-protection, protection of customers, and protection of the environment.
- To provide basic inputs for the application of biosafety protocols.
- To provide information and orientation to customers by facilitating patient flow by adequate internal and external signage.
- To assess adherence by hospital staff to protective measures.
- To reward and recognize best practices and results.

The general approach for implementation of this component included training on biosafety norms and regulations; selection and assessment of target areas; hospital waste management; and monitoring of adherence to norms. In addition, this component promoted the establishment of an epidemiological surveillance system to support and monitor prevention of nosocomial infections and occupational risks caused by biological agents. Finally this component encouraged evidence-based decision making by responsible hospital staff in order to maintain a safe and quality enhancing environment.

The specific operational steps were:

1. To prepare a situation analysis.
2. To develop and implement "risk mapping" or risk assessments.
3. To make hospital staff aware and provide training on biosafety principles and practices for adequate hospital waste management.
4. To develop and apply checklists for hand washing and correct use of protective gear (gloves, masks, gowns).
5. To apply a self-evaluation checklist for emergency, sterilization, surgery, and labor and delivery services.
6. To apply a tool for assessment of biosafety behavior in high-risk or critical areas.
7. To establish Biosafety Committees.
8. To provide equipment, supplies, and some hospital renovations to implement biosafety standards and practices, including some signage of risk areas.

In addition, the project provided surgical clothing and fields, cabinets, air conditioners, transportation carts for clean and dirty linen, trash cans for select types of waste, surgical handwashing equipment, lockers, soap dispensers, stretchers for patient transportation, curtains for emergency wards, and cleaning supplies and materials. REDSALUD also conducted renovation work in specific areas of four hospitals in the Eastern Region (Guaymate, Dr. Teófilo Hernández Hospital, Srta. Elupina Cordero Hospital, and Dra. Evangelina Rodríguez Perozo Hospital in San Rafael de Yuma). Water pumps and storage tanks were purchased and installed. All of this work was closely supervised by project staff or by specialized technical advisors.

Another important aspect was the monitoring and evaluation systems put in place to assess progress in this component. A 10-parameter scoring sheet was applied to different groups of participants along several key dimensions of biosafety knowledge and practices. All achieved passing scores upon completion of the program. These assessments were complemented by external evaluations of actual biosafety practices and behaviors. A total of 12 of the 14 hospitals in the Eastern Region were evaluated and all demonstrated significant progress. Results from this formal assessment served to select a group of hospital representatives which participated in a study tour in Medellin, Colombia, as a reward for their efforts and commitment.

Work on improving patient safety standards and practices led to the following results:

1. A majority of health care personnel is aware of biosafety norms and practices, which enhances institutional capacity to offer quality care to customers.
2. Learning about the situation of their working environment and the potential risks faced led to greater involvement and behavior modification in favor of personal protection and customer care.
3. Institutional shortcomings were overcome when enough interest and commitment were displayed by participants. This component faced staff turnover, a natural disaster, and political uncertainty, but was nonetheless able to achieve its goals within the timeframe established.
4. Hospital executives and managers must be involved in the supervision and follow up of these activities, which should be seen as part of their routine duties and responsibilities.

5. Formal regulations will be necessary to standardize biosafety practices.
6. Involvement of government leaders and the community at large is required to secure support and sustainability.

The **third stage** of OAU implementation was related to improving patient flow. To this end REDSALUD supported the strengthening of patient records management by organizing and reviewing existing records, and by developing a computerized records catalogue in selected hospitals to facilitate storage and retrieval of records. During this stage the project also supported the assessment and design of an admissions and patient appointment system for hospitals in the Eastern Region. A short survey was completed, along with a review of current patient files and flows in order to devise an appropriate course of action.

The **fourth stage** focused on social mobilization and social participation. This was accomplished by signing an agreement with the Social Security Ombudman's Office (DIDA) in order to develop a regional strategy for social mobilization. The MOH and SENASA were also involved in this effort which focused on 4 lines of action:

- Health promotion and disease prevention
- Social oversight and improved awareness about citizen rights and responsibilities under social security
- Enrollment into to different regimes of the social security system
- Institutional governance at the hospital level (Boards of Directors)

This intervention trained social security facilitators at the community level, assisted in the enrollment of SENASA beneficiaries, and promoted broad awareness of social security health benefits. It also contributed to organizing community-based board of directors in selected hospitals, who were trained in hospital policies and procedures. This work was completed in order to move hospitals towards greater decentralization as required by Law 87-01.

Third Generation Demonstration Projects: Strengthening Management Capacity of SESPAS Hospitals in the Eastern Region

The third generation demonstration projects intended to develop and strengthen the management and organizational capacity of each one of the 14 SESPAS hospitals in the Eastern Region, in order to strengthen their institutional capacity to use resources more efficiently and improve the quality of services offered. These projects were built around the structure, staffing patterns, resources, and service portfolio of each hospital.

During the first quarter of fiscal year 2003, hospitals in the Eastern Region signed grant agreements to develop 7 projects whose main objective was strengthening their administrative and financial capacity by implementing strategies to conduct **service portfolio analysis, service costing, analysis of productivity, prospective budgeting, and information systems**. Hospital teams carried out the ***analysis of service portfolios*** and delivered a first round of reports. This exercise was repeated in late 2004 to produce a second round of updated reports. These reports included market analyses in each hospital's catchment area which allowed for an in-depth understanding of supply and demand of health services. This knowledge was important for public providers to reorganize their services in order to offer integrated care as required by law. In addition, by making use of all resources available in the community, this analysis served to improve and rationalize the supply of health care services and discuss network arrangements. In addition, results of this exercise were used to discuss contracting and payment arrangements with SENASA based on the type, quantity, and quality of services that hospitals were capable of providing to potential enrollees.

Another aspect of hospital management strengthening was the development and application of a ***costing tool*** to allow for easy monitoring of the finances and costs of each service, for each hospital. This tool included a simple worksheet that collected and analyzed hospital direct and indirect costs. This tool was installed in each of the participating hospitals in the project. Training was conducted by local consultants who interacted closely with hospital staff involved in this exercise. In fact, consultant performance was assessed by the level of understanding and practical skills shown by hospital trainees. Results allowed not only to learn about the cost structure of hospital services in the Eastern Region, but also to begin making decisions based on results. Since this information was shared and discussed by all hospital personnel, particularly medical staff, measures were considered to correct some of the problems found, such as increasing costs due to poor productivity or due to inappropriate resource use.

Two rounds of hospital cost analyses were completed during the life of the project. Hospital teams were encouraged to participate by setting up a regional contest which led to public recognition of the best performers. As a reward representatives from these teams participated in a study tour to Medellin, Colombia, to learn further about costing and overall hospital management among public facilities in this city.

In addition, ***prospective budgeting*** was designed to strengthen the capacity of Dominican public hospitals in the Eastern Region to operate as autonomous, efficient organizations. Public hospitals in the Dominican Republic are traditionally funded through partial government transfers following the structure of historical budgets. These budgets are partial since a large proportion of resources are directly managed by the central level of SESPAS through expenditures on personnel, equipment, or commodities. This phenomenon is, of course, rather typical of most developing countries with limited progress in health reform. In the Eastern Region this management tool was developed in anticipation of the new health and social security law which transformed supply-side subsidies into demand-side subsidies for health care financing under conditions of a quasi-internal market for public hospitals. The new law introduced the notion of a purchaser-provider split where the former is the National Health Insurance Fund (SENASA) and the latter are SESPAS hospitals.

Prospective budgeting consists of the preparation of hospital budgets based on the future costs and demand for services. This is a major departure from the status quo among Dominican public institutions which hinders adequate and efficient resource use. Prospective budgeting was a natural next step in this sequence of hospital management strengthening that followed service portfolio analysis and costing. In fact, these two interventions were the basis for successful prospective budgeting.

This intervention faced several difficulties in the DR given the nature of supply-side hospital financing, the lack of real cost data, and the weak managerial capacity of hospital teams, among other factors. Prospective budgeting was implemented by a team of local consultants who received technical guidance by REDSALUD staff. The method consisted of estimating demand (i.e. future utilization) given epidemiological and demographic conditions in the catchment area, as well as service portfolio analysis (i.e. supply). Prospective budgets were derived by combining potential demand with cost data in all 14 public hospitals in the Eastern Region. The value of this tool lies in the ability to develop an evidence-based budget using client utilization, service production, and cost data. Having a prospective budget allows hospital management teams to become aware of basic financing principles that may support rational decision making leading to improved efficiency. This tool also helps to enable institutions prepare sound justifications for resource allocation.

Another area that REDSALUD worked on was strengthening the technological platform to produce, manage, and use ***information*** in a modern health care system. To this end the project provided computer equipment to all 14 MOH hospitals in the region, as well as necessary software. In addition, network capability was developed in all facilities in order to facilitate electronic communications within each

hospital and among hospitals, in preparation for the organization and operation of an autonomous regional provider network.

Graduate Program in Health Service Management and Social Security

Following the approval of Law 87-01 to establish a new social security system which introduced significant changes in the way health care services are organized, managed, and financed in the Dominican Republic, USAID supported the idea of establishing a graduate program in health services management and social security in the Dominican Republic. The purpose of this program was to develop a cadre of professional health care leaders and managers capable of responding to the new challenges brought about by the health reform process, particularly at the hospital level.

REDSALUD was the vehicle used to channel USAID support for this initiative given the project's influence in the DR's Eastern Region, where it implemented several demonstration projects in support of SESPAS programs and services. As mentioned earlier, the project targeted financial and technical assistance to 14 small to mid-size hospitals (ranging from 30 to 200 beds), some 50 primary care clinics, and a total of about 2,000 SESPAS technical and support staff. The graduate program was developed to train senior and mid-level SESPAS managers in this region.

The scope of work for this program was prepared by the REDSALUD team with support by an international consultant, who interacted with local partners and other stakeholders. Several universities which offered graduate education programs in health care were visited. In addition, results of a human resource survey conducted in the Eastern Region were reviewed.

Local universities were invited to submit bids responding to specific terms of reference prepared by REDSALUD. A total of six institutions submitted proposals. An evaluation committee comprised of representatives from REDSALUD, USAID, and SESPAS assessed all proposals using explicit criteria. INTEC University from Santo Domingo was selected to implement the academic training program. REDSALUD arranged with CES University from Medellin, Colombia, to conduct a series of "standardization" seminars and workshops for INTEC faculty in order to enhance their understanding and skills to design and implement a graduate program in the context of health reform.

The INTEC program comprised a total of five quarters or cycles, each lasting 11 weeks with approximately 120-130 contact hours (Annex 4). Classes met on Fridays and Saturdays. Academic cycles were organized as follows:

- A standard cycle
- A basic cycle
- A management cycle
- A resource management cycle
- A thesis research cycle

Starting in the 3rd quarter students were required to carry out supervised tasks at their place of employment applying the knowledge and tools acquired. These tasks were supervised by INTEC instructors who performed site visits.

The program started in August 2003 with a first cohort of 30 students selected from a pool of 80 applicants. Another cohort of 30 students was added in February 2004 out of a pool of 85 applicants. The student recruitment process was handled by INTEC following usual admissions criteria. Graduates of this program are recognized as specialists in health management and social security.

In order to be considered for a REDSALUD/USAID scholarship (approximately US$16,000 per student) participants had to comply with all INTEC academic requirements. In addition to individual course evaluations a general program evaluation took place every two months with participation by REDSALUD staff, INTEC, and students.

Based on information shared during evaluation meetings the following results were observed. The program had a positive impact in developing and strengthening managerial knowledge and skills among students. This was evidenced through field visits to SESPAS' places of employment for students. A noteworthy example was Ramon Santana Hospital in Macoris Province, where 5 staff members participated in the program. They made extensive use and actually expanded management tools in order to address hospital problems. This resulted in objectively measurable improvements in utilization, resource management, and overall performance by this hospital.

Similar trends were observed in other facilities despite uneven levels of institutional development and varying degree of interest by students. A formal external evaluation of this program was carried out in the Spring of 2005 by a technical team from CES University. The evaluation team was satisfied due the program's broad acceptance among students, employers, and future graduates, which was found to be a strength for future scholarly developments. The evaluation team made important recommendations for sustained success, however, some of which are highlighted below.

- The program should promote research opportunities with INTEC support.
- A dissemination mechanism for policy development, i.e. a journal specializing in social security reform, is necessary.
- The academic content should be expanded to include a health care auditing, evidence-based management, technology assessment, and project management.
- Greater flexibility for students to complete academic requirements was suggested.
- Opportunities for hands-on internships for students should be identified.
- Greater access to the program through innovative outreach strategies should be promoted.
- Strategies for additional financial support for the program, including consulting by INTEC, should be sought.

These recommendations should be taken into consideration by USAID and INTEC in order to move closer to long-term academic and financial sustainability by this graduate program.

In addition to the formal academic training offered by INTEC under a subcontract with Abt/REDSALUD, the project developed a complementary **in-service training strategy** focused on mid-level service managers and technical staff. The purpose was to offer short on-site courses on basic management skills to a larger group of SESPAS employees in the Eastern Region. The approach followed was an invitation to submit competitive bids by local universities and other training institutions. Several universities were selected to design training modules on information systems, human resource management, customer relations, etc. Due to a number of difficulties only one agreement was signed and implemented with *Universidad Central del Este (UCE)* in San Pedro de Macoris province. Other institutions were unable to fulfill technical and timing requirements. This activity was eventually dropped.

Fourth Generation Demonstration Project: Supporting the Development of the New Health and Social Security System in the DR's Eastern Region

As mentioned above, Law 87-01 established a new health and social security system in the Dominican Republic and its main features have already been described. This aspect of the project was not contemplated in the original proposal of REDSALUD except to mention that major reforms were in the works at the time it was submitted to USAID. In 2001, almost 10 months after the project was launched, the Dominican congress approved a new legal framework to revamp the health and social security system. This was seen as the "most significant development in social policy in the nation's history." This new context led the field team and USAID to reassess the project's mandate and scope of action.

The National Council for Social Security set up a timetable for start up of the new system that was supposed to begin on November 1, 2002 in the Southwestern Region and on March 1, 2003 in the Eastern. Adequate implementation of the new health and social security system and compliance with the objectives of universality, solidarity and equity implied a great challenge for the institutions involved both at the regional and national level. This required close coordination and planning in order to set up the groundwork for the new system in the five provinces of the Eastern Region with an estimated population of 900,000, a third of which were believed to live under the poverty line.

Hence the need for REDSALUD to design and implement a regional demonstration project that would provide technical and financial support to implement a series of activities. In addition, it was envisioned that new agencies created under the law would take on their appropriate role and carry out priority actions to establish the new health and social security system in the region. This new demonstration project would complement and strengthen other initiatives that REDSALUD pursued in the region in order to improve access and sustainability of basic health services for poor Dominicans. The project began implementation in 2003 for a duration of 12 months that were later amended to a total of 2 years.

The general objective was "to support start up of the family health insurance by means of a demonstration project which will provide technical and financial assistance in order to contribute to organize key stakeholders for social security in the Eastern Region." Specific objectives included:

1. To support SENASA, SESPAS and SISALRIL in the identification, registration, and selection of social security members through the design and application of a pilot system.
2. To support SENASA in the design and application of a system to capture and register members of the public contributive regime.
3. To support the Office of the Deputy Minister for Primary Care in collecting social, demographic, and epidemiological data about SESPAS users in the region through data collection and processing of family charts ("fichas familiares").
4. To support SENASA in the design and implementation of a payment mechanism and contracting of health service providers.
5. To contribute to the development of institutional capacity at SENASA for purchasing of care through the design and application of service agreements or contracts.
6. To contribute to the development of a working relationship between SESPAS and SENASA by supporting the design and implementation of a performance agreement system in the Eastern Region.
7. To contribute to the development of a costing system at SESPAS and SENASA in support of the design and implementation of a prospective budgeting mechanism.
8. To contribute to SESPAS' and SENASA's efforts to develop a management information system that will provide timely data about users.
9. To assist SESPAS providers to prepare invoices for services offered to SENASA through the design and implementation of an invoicing system.

10. To assist in the development of citizen oversight and accountability capacity among institutions that support DIDA, as well as among community groups in support of supervision and information dissemination about the social security system.
11. To support SISALRIL in the design and implementation of a regional mechanism for monitoring and evaluation of relevant activities.

The strategy followed by the regional demonstration project was based on the need to develop a shared management model that would include all key institutions in the Eastern Region, such as health service providers, provincial health directorates, the regional health directorate, the Sub Secretariat for Primary Care, the National Health Insurance Fund (SENASA), Ombudman's Office for Social Security (DIDA), the Superintendent's Office for Health and Labor Risks (SISALRIL), and the organized communities.

This strategy included the following components and activities:

Technical Support. To provide technical assistance for human resource development among involved entities and to support the design, development, and implementation of systems and tools proposed under the project's objectives. This component considered the following activities:

1. Hiring of local and international consultants to support the development, implementation, evaluation, and updating of tools and strategies proposed for the regional project.
2. Developing and utilization of computer-based information tools in support of project activities.
3. Training of personnel in the management and maintenance of tools and strategies used.

Information, education and communication. To inform, educate and communicate to members of participating entities and project beneficiaries about advances and progress related to the accomplishment of project objectives and overall implementation of social security in the region. This component envisioned the following activities:

1. Design, preparation, and utilization of IEC tools and strategies in support of project objectives.
2. Design and implementation of evaluation activities for mass in order to assess impact of IEC activities.
3. Compilation of documents and bibliography related to health systems reform in order to organize a specialized Regional Library.

Study tours. To sponsor and carry out visits in country or to international settings in order to learn from similar experiences and allow exchange of knowledge and ideas related to project objectives. This component would carry out the following activities:

1. Conduct study tours and other academic activities in order to share national experiences about themes related to project activities.
2. Invite international experts to discuss issues and opportunities related to implementation of similar experiences.

Provision of basic furniture, hardware, and installation facilities. To furnish working space; to procure, install, and maintain information, communication, and management equipment and tools, in support of general project activities. The following activities would be supported:

1. To provide workstations with equipment, furniture, and basic tools for information and management activities included in the demonstration project.

2. To support minimal renovation of work settings, such as securing energy supply and surge protection according to project objectives.
3. To carry out basic maintenance activities for equipment and tools used for the project, as well as to provide training for local personnel responsible for such maintenance.

Community Participation. To strengthen local community capacity to exercise supervision and social participation through motivation, organization, and adequate integration in project-related processes. The following activities were planned for this component:

1. Identification, organization, and training of community support groups to the reform process, in accordance with the objectives established for the project.
2. Conduct community activities to define and sign performance agreements and promote accountability by authorities and key health sector players in the new system.

Monitoring and evaluation. To design and implement methodologies, procedures and instruments that allow for constant monitoring and evaluation of the project and its results. The following activities were considered for this component:

1. Design and implementation of surveys, census or investigations to support project evaluation and support decision making in order to achieve the objectives of the project.
2. Conduct public evaluations and present results.

Dissemination of experiences. To raise awareness at the national and international levels via technical reports, strategies and instruments developed during implementation of the Project to share ideas on what may be useful in other places and processes. The following activities were envisioned:

1. Elaboration of technical reports, manuals and other project outputs, such as publications, and dissemination by different means and strategies.
2. Conduct academic activities to present and discuss experiences.

By all means, this was an ambitious and challenging program. Below is a brief description of the most significant achievements for each of the specific results stated above.

Identification, registration, and selection of social security members through the design and application of a pilot system. The first step in the operation of a social insurance program is a clear definition of the target beneficiaries based on specific criteria, known as "means testing." In addition to knowing who the beneficiaries are, it is important to verify their identity in order to minimize fraud and payment leaks, common problems in insurance administration. The purpose of this activity therefore was to assist in the design of a system capable of registering population eligible for insurance coverage under the social security's family health insurance program (subsidized regime) managed by SENASA. This was necessary given the impending start up of the program in March 2003, as had been publicly announced. The approach initially implemented by REDSALUD was to carry out a census of population in preselected poverty areas, as defined by a "government poverty map" prepared back in 1998. This allowed the collection of data in geographically targeted areas in the Eastern Region using a form jointly developed with SENASA. Teams of census takers and supervisors were trained and deployed in the region. After several months' worth of work in late 2003, data from approximately 70,000 households (210,000 individuals) were collected. The expectation was that these data would be reviewed and validated by the Social Security Council and the Treasury for Social Security in order to obtain final authorization for formal enrollment in SENASA. It should be noted here that this approach differed substantially from the one used in the Southwestern Region of the country where a similar process of enrollment was taking place using "family charts." The REDSALUD team and SENASA considered this

tool inappropriate for health insurance eligibility purposes and thus chose not to use it in the Eastern Region. Experience later showed this was the right decision as SESPAS had to do over most of the data collection work in the Southwestern Region.

This first effort proved fruitless, however. As it turns out, there was no funding available to support the new family health insurance program for the subsidized population. In addition, there were significant policy-level constraints since SESPAS authorities were reluctant to accept the new demand-side health financing scheme. Both the Social Security Council and Treasury were not ready either to proceed with validations. Finally, some data collected and submitted for validation checks were apparently mixed up with less useful data, which created validity and accuracy problems.

During the project's fifth year of operation, government change in August 2004 brought about renewed interest in the family health insurance program as part of a package of social measures to alleviate poverty. Under the Vice President's leadership, who made a formal request for assistance to USAID, REDSALUD began working on a second effort to identify and select poor families in the Eastern Region. The project's team assisted in the design of a new instrument for the Unified System for Identification of Beneficiaries (*Sistema Unico de Beneficiarios – SIUBEN*) which would create a national database of families eligible for social welfare programs. This was a complex and time consuming endeavor. After several months of intense work REDSALUD delivered to the Social Cabinet approximately 110,000 individual records with relevant data. These records were processed under contract by the Instituto Tecnologico de Las Americas (ITLA). At the time of this report the Social Security Council was carrying out a slow and cumbersome process of record validation prior to formally authorizing enrollment.

Supporting SENASA in the design and application of a system to capture and register members of the public contributive regime. REDSALUD provided technical assistance to SENASA to develop a system for identification, selection, and management for beneficiaries of the family health insurance program. This system may be adapted to capture data from public employees which would be covered by the public contributive regime. By end of project this process was yet to begin.

Supporting the Office of the Deputy Minister for Primary Care in collecting social, demographic, and epidemiological data about SESPAS users in the region through data collection and processing of family charts ("fichas familiares"). This objective was included in this project in order to provide some assistance in the collection of family chart data for health assessment purposes, not for determination of insurance eligibility. Several hundred charts were filled out in Hato Mayor, El Seibo, and La Romana provinces. These charts had been questioned from a technical standpoint since data were collected by community workers with little training in clinical diagnosis or epidemiology. Data validity, accuracy, and reliability were major issues.

Supporting SENASA in the design and implementation of a payment mechanism and contracting of health service providers. This result was achieved through study tours, international short term technical assistance as well as support by the local REDSALUD team. Several meetings took place with SENASA staff to discuss different provider payment options and a draft service agreement for SESPAS providers. Important inputs for this work were costing and service portfolio analysis data obtained through the hospital strengthening demonstration projects. These activities helped SENASA develop a master service agreement with SESPAS providers which was used in both the Southwestern and Eastern regions. REDSALUD also provided assistance in the development of auditing capability at SENASA.

Contributing to the development of a costing system at SESPAS and SENASA in support of the design and implementation of a prospective budgeting mechanism. This objective was included also in the hospital strengthening demonstration projects. Implementation details and main results are described there.

Contributing to SESPAS' and SENASA's efforts to develop a management information system that will provide timely data about users. This objective was part of the overall approach by REDSALUD to strengthen health management information systems in the Eastern Region. A number of information technology applications or "tools" were developed and have been described elsewhere in this report.

Assisting SESPAS providers to prepare invoices for services offered to SENASA through the design and implementation of an invoicing system. A good foundation exists in the Eastern Region to prepare invoices, based on several management and information technology applications, such as the patient registration form, the costing procedures, service portfolio analysis, and logistics management, to name a few. In addition, the improved management culture and in-depth understanding among regional managers of the operation of the health and social security system in the DR make this objective fully feasible when the time comes to produce invoices.

Assisting in the development of citizen oversight and accountability capacity among institutions that support DIDA, as well as among community groups in support of supervision and information dissemination about the social security system. This result was materialized through a formal cooperation agreement between DIDA and REDSALUD. Other demonstration projects also contributed to this result. Broad social mobilization, organization and training of community groups, awareness raising workshops and events, and social participation activities were carried out as part of this objective. The most salient output was perhaps the selection and appointment of "boards of directors" in several hospitals in the region that are increasingly involved in oversight and management support activities.

Supporting SISALRIL in the design and implementation of a regional mechanism for monitoring and evaluation of relevant activities. SISALRIL was initially a key beneficiary of REDSALUD assistance in terms of drafting the basic package of care, developing internal regulations, proposing its basic structure and functions, and supporting the operation of a regional office.

Strategy 2. Support of Central Ministry of Health (SESPAS) Strengthening

The main purpose of this strategy was to support and facilitate SESPAS' transition process from its multiple roles as steward, regulator, payer, and service provider, to a new, specialized role under a separation of functions scheme, following the new legal and regulatory framework in the DR. This strategy also intended to serve as a bridge between demonstration projects at the local level and potential institutionalization at the central level. This strategy carried out activities to strengthen the central level capacity for deconcentration and decentralization by supporting processes related to planning, budgeting, information systems, epidemiological surveillance, human resource management, licensing and accreditation, among others. Coordination with other initiatives in support of SESPAS was an important aspect in the implementation of this strategy. As demonstration projects presented effective solutions this component supported their understanding, adoption, and dissemination at higher levels of SESPAS and other relevant institutions.

Operational Approach

The following strategic options were used in pursuit of the above mentioned objectives.

Cooperation to enhance stewardship and coordination capacity of the central and local level of SESPAS. This component facilitated continuous communication, information sharing, and coordination with different units of the central level of SESPAS as well as other donors. Noteworthy are working relationships established on behalf of REDSALUD with the Vice Ministers' offices in charge of technical affairs, collective health, and service delivery. Likewise with CERSS, PAHO, PROSISA, CONECTA,

Project HOPE, UNICEF y several non-governmental organizations. This work required submission of periodic reports, attendance to meetings, document sharing, among other activities.

Technical assistance to central-level programs such as maternal and child health (MCH), immunizations, epidemiology, HIV/AIDS, tuberculosis control, quality assurance, human resources, in order to strengthen management capacity and support to the local level in the context of reform. Planning support and human resource development were core activities for the MCH program. Likewise, EPI received technical assistance in annual planning; organization and monitoring of vaccination campaigns; vaccine evaluation (i.e. pentavalent vaccine); clinic accreditation; and institutional strengthening in the context of reform. This program was one of the most open to understanding and responding to challenges imposed by the new environment. REDSALUD also assisted in the preparation of regulations for human resources, epidemiological surveillance, and information systems, among others.

Cooperation in the definition of roles and responsibilities of central-level programs in the transition process. Specific assistance was provided to the human resource program, EPI, tuberculosis control, MCH, laboratories, and blood bank to review and update roles and responsibilities in the context of separation of functions and deconcentration of sanitary authority. This was carried out through extensive meetings and discussions with policy makers and technical managers. Study tours were organized to raise awareness and technical competence among EPI and blood bank managers.

Integration with other technical areas of REDSALUD. Staff involved in the implementation of this strategy participated and supported activities implemented by other technical components of the project. This was particularly important as an expression of effective integration across the project.

<u>Support local planning and management of HIV/AIDS prevention and control</u>
REDSALUD supported the central level of SEPAS by providing technical cooperation to national programs such as Primary Care, EPI, HIV/AIDS, TB, among others. In relation to HIV/AIDS, REDSALUD was assigned the role of facilitating the national program's deconcentration in the Eastern Region, consistent with the new legal framework. This was a challenge since the program is fragmented at the national level with several players claiming tenure and disputing decision and action space. The key counterpart was SESPAS' National Directorate for Control of Sexually Transmitted Infections and AIDS (DIGECITSS). After a slow start between 2000-2002, a situational analysis was carried out in the region in coordination with DIGECITSS to update general information about the epidemic; prepare an inventory of public and private institutions, NGOs, CBOs, and donor activities; identified the needs for STI/HIV/AIDS services; and estimated unmet demand within target groups. Field visits were conducted in La Romana, La Altagracia, San Pedro de Macorís, and El Seibo to explore possibilities and discuss DPS involvement. Information dissemination also took place regarding the new legal framework, social security, and the roles of key players in the HIV/AIDS area.

Once the information was available, a work plan was developed for the year 2003, whose goal was to assist in the mitigation of the HIV/AIDS epidemic in the population of the Eastern Region in the context of health sector reform. The plan set out the following objectives:

1. Disseminate results obtained by the assessment of the HIV/AIDS situation.
2. Update the HIV/AIDS Provincial Operational Plans (POP).
3. Strengthen the POP follow-up committees.
4. Strengthen management capacity of key players to promote both STI/HIV/AIDS prevention projects and care to people living with HIV/AIDS in the region.
5. Strengthen the regional information system to monitor and prevent mother-to-child transmission, in the context of MCH program development.

Results of the situation analysis were broadly disseminated at the regional level and among key national agencies involved in HIV/AIDS prevention and care activities. This set the stage to mobilize DPS and DRS to work on POPs. Several planning workshops were conducted for this purpose, facilitated by SESPAS staff. The majority of the workshops were attended by the DIGECITSS General Director, the Health Provincial Directors, and REDSALUD staff. In addition, introductory presentations were conducted by the DIGECITSS personnel, and, in some cases, by the General Director. Participants from several institutions were highly motivated and committed to pursue this endeavor. Five multi-sectoral follow-up committees were formed to monitor progress in the planning effort, and were training in basic project management and advocacy skills.

Activities implemented included:

- Information sharing and awareness raising among health service personnel to reduce discrimination against persons living with AIDS (PLWAs).
- Information dissemination and awareness raising among religious leaders.
- STD/HIV/AIDS training workshops for youth peers and students.
- ABC-oriented lectures regarding STD/HIV/AIDS information and awareness raising.
- Community events to raise population awareness about HIV/AIDS, using neighborhood committees, health boards, etc.

With support by a local consulting firm the project began the development of a Regional Maternal-Child Information Module (SAAMI) for the health information system in the Eastern Region. This module was designed to collect data from pregnant women (prenatal care and follow-up during childbirth and post-partum stages) in order to facilitate a special follow-up for HIV-positive pregnant women and their newborns, referring them to the HIV Mother-to-Child Prevention Program.

Strategy 3. In Support of a Favorable Policy Environment for Health Sector Reforms.

This was the third operational strategy implemented by REDSALUD. This strategy was supported throughout most of the project's life by a Dominican partner institution, the National Institute for Health (Instituto Nacional de la Salud, INSALUD). This strategy experienced two distinct phases: the first with support by Guillermo de la Rosa, INSALUD's executive director, who died prematurely at the end of 2002. The second phase corresponded to the second half of the project under direct control of the REDSALUD team. The general purpose of this strategy was to develop policy support for health reform among key institutions and at the community level in the DR. To this end the project implemented a series of operational strategies including information dissemination, policy dialogue initiatives, advocacy interventions, and social mobilization. This strategy also supported demonstration projects in the Eastern Region.

Information dissemination took place by means of the preparation and distribution of nine quarterly REDSALUD bulletins reaching an audience of approximately 1000 individuals and institutions. These bulletins included current information of interest, health news events, and management tips. In addition, the project hosted a website where project information was posted. Several presentations and events were organized throughout the life of the project for media representatives, medical association groups, and other stakeholders in order to raise awareness and support for the reform program. During the first three years of the project REDSALUD sponsored the preparation and dissemination of media content analyses that were appreciated by institutions in the sector.

Policy dialogue activities comprised policy discussions during the preparation of the new legal framework, especially the social security law. REDSALUD staff interacted with members of congress

and other interested parties to examine specific aspects and implications of this new law. Later the project participated in the elaboration of implementing regulations, a process that took an inordinate amount of time and effort given the limited experience of local counterparts, with some donors and technical assistance agencies adding to the confusion. REDSALUD co-sponsored the realization of several National Health Fora organized by INSALUD and other civil society organizations. These fora served to debate and reach consensus about pressing issues in the national health agenda. Unfortunately these events were mostly ineffective to help move from rhetoric to action. Through this strategy the project made several attempts at promoting coordination among local stakeholders, donors, and other social players. None of these efforts were successful or sustainable. Lack of coordination is probably one of the most serious weaknesses in the Dominican health sector, reflecting the institutional weakness of the Ministry of Health.

Finally, this strategy was also pursued through a few advocacy activities. A stakeholder analysis was conducted early in the life of the project. The project facilitated data collection for a pilot test of the Decentralization Mapping Tool. Results of this test confirmed the absence of progress in decentralization in the Dominican health sector since 2000. Other advocacy activities were implemented specially during the local electoral cycle, seeking to raise understanding and awareness among political leaders. During the project's last year an important effort was the formulation of a National Health Agenda by an array of non-governmental organizations with the occasion of the 2004 national elections. This activity promoted significant debate on supporting social security and health as poverty-alleviating and social equity policies.

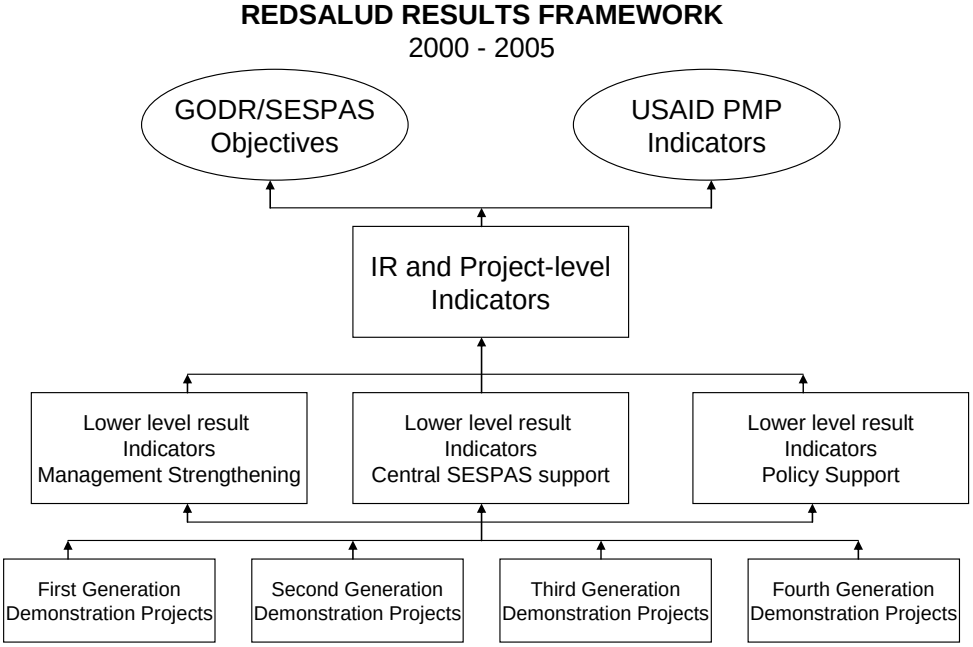
IV. Monitoring and Evaluation of Project Results

Monitoring and evaluation was a critical aspect of the REDSALUD project. It was important to show and document the effects of demonstration projects on the current state of SESPAS services in the Eastern Region. It was also important to provide USAID with data for its internal reporting needs. Monitoring and evaluation measurements relied on special efforts to collect relevant data, such as in the case of the Management and Autonomy Index or user satisfaction surveys. In other cases REDSALUD relied on data routinely collected by SESPAS to monitor program effectiveness, such as EPI coverage or outpatient consultations. In the latter case, data suffered from a number of problems. In any case, the project team made significant efforts to document progress in an as rigorous and complete manner as possible.

The fundamental objectives of REDSALUD's monitoring, evaluation and reporting plan were to 1) provide an opportunity for self-evaluation for the REDSALUD Project, USAID and stakeholders, 2) ensure accountability with USAID, communities, and other stakeholders, and 3) create a learning process for both local sites and national counterparts through the ME&R experience. The results of the REDSALUD evaluation were also expected to expand the larger body of health sector reform knowledge, particularly with respect to strengthening of local health care organizations in the DR's Eastern Region. REDSALUD results could offer significant insights into the ways in which public sector resources should be managed to achieve the goal of delivering accessible, efficient, and high quality health services. However, the REDSALUD evaluation framework focused not only on end results. It was part of an interactive, continuous cycle that used data to inform project staff and stakeholders, and then used feedback to improve the work of the project.

The diagram below shows different levels for project monitoring and data flow. At the bottom are the four generations of demonstration projects, which fed upwards to the component-level indicators. Above are the intermediate level and project-level indicators. At the top are the USAID performance management plan (PMP) or strategic objective indicators and indicators of the host government level. The latter were not examined by the REDSALUD project. Demonstration project level indicators

(process and outcomes) were briefly discussed in previous sections. This section focuses on PMP and project level indicators.



Program Management Plan (PMP)-level indicators

Increased Efficiency and Equity of Basic Health Care Services at the Local Level

Indicators: use of basic health services by the poor; service productivity ratio.

This intermediate result experienced a paradoxical behavior during the life of the project. On the one hand, the first indicator of service utilization (as a proxy for **access**) by the poor reflected an upward trend across the three measurements completed in 2002, 2003, and 2004 (70.8%, 73.2%, and 83.4%, respectively) with an overall increase of 18%. This indicator examined the combined utilization of vaccination services and general outpatient service use by poor population in the Eastern Region, namely SESPAS users. The upward trend may be explained particularly by the relative effectiveness of vaccination services, which were a special focus of REDSALUD interventions. These services were somehow protected from the state of flux that affected SESPAS during most of the period in question. The second element of this indicator, outpatient service use, seems to have had a different behavior as explained below.

The second indicator was a productivity ratio based on the combined assessment of both the number of vaccination services and the number of outpatient visits (outputs) produced per hour of personnel time (inputs), as a measure of **efficiency**. In contrast to the previous indicator, this one showed a downward trend during this reporting period, for an overall decline of 30%. The results were, on average, 2.27 outputs per staff- hour for 2002, 1.8 for 2003, and 1.6 for 2004. This indicator was sensitive to the institutional chaos experienced by SESPAS during most of the 2000-2005 period characterized by frequent budget shortfalls, physician strikes, supply stockouts, and other problems. This indicator showed how, unless there exists some degree of functionality in the local health system, donor cooperation will only have a limited effect. Thus the importance of partnership assumptions between host country and donors when implementing development projects.

Improved capacity of health system to implement an effective decentralization strategy
Indicator: Autonomy score
This result had to do with assessing the system's ability to implement decentralization, an important outcome of the new legal framework in the DR. This indicator was measured by a subset of items in the management and autonomy index survey. The indicator increased between the first and second observation (34.1% to 40.6% in 2002 and 2004, respectively), but leveled off between the second and 2005 observations. This appears to reflect what occurred in the field between the first and second halves of the project. Initially there was some degree of interest and motivation, along with stability. Later chaos took over and was compounded by SESPAS movement from one crisis to another, in the context of serious national instability.

Strengthened management capacity of selected health areas and provincial directorates
Indicators: Local management capacity score

This result was measured by results from the management and autonomy index surveys. These were surveys designed and implemented by REDSALUD with collaboration by subcontractor CONSAD. These surveys collected data from approximately 200 SESPAS facilities in the Eastern Region at three moments in time: 2002, 2003, and 2005. Each survey calculated an overall non-adjusted score, a score adjusted by coincidence, a score adjusted by coincidence and verification, and an overall score adjusted by coincidence and verification. It should be mentioned here that the survey instrument included a verification checklist in order to assess "politically correct" responses or Hawthorne's effect in survey research. It turns out that once the verification adjustment factor was applied to the overall score, it usually dropped by about 50%. This was an important lesson learned. This score showed an upward trend during the observation period, with an overall increase of 37% between baseline and the last measurement. This may be attributed to REDSALUD interventions to strengthen management capacity in the Eastern Region, by promoting training activities, tool development and use, information system advances, organizational development, and similar activities.

Improved health policy environment for reforms
Indicator: Milestone score of policy process

This result focused on the overall policy environment for health reforms as illustrated by the social security mandates. The indicator assessed institutional development of the National Health Insurance Fund (SENASA) as a proxy for the policy process underway in the DR. This agency was selected in view of its role managing the government-subsidized family health insurance for the poor. This was and is closely related to USAID's strategic objective. SENASA did not exist when REDSALUD began operations. It was one of the new institutions created by the new social security law. REDSALUD provided extensive technical assistance and financial support as documented in a previous section. This indicator showed an overall increase of 65% between 2003 and 2005, mostly due to progress in enrollment of eligible population in the Southwestern region as well as institutional capacity building at the national level. Progress achieved in the Eastern Region has been more elusive at the time this report is written.

USAID's External Evaluation of the Health Reform Strategy

In 2004 USAID sponsored an external evaluation of its health reform support strategy, including the REDSALUD project.[5] The evaluation team carried out extensive review of USAID documents and reports, project reports, and conducted several field visits. At the end their main conclusion was:

> *"…..USAID's strategy has been correct, coherent and viable, and that its sustainability depends on the reform course and the health policies of the country. The focus of USAID's program is relevant and has been executed according to plan. In regards to REDSALUD, the evaluation team found that both the original design and the changes made during the course of the project were reasonable. The demonstration project generations of the project have worked adequately. There was clear satisfaction among the Health Region V provincial and regional employees, as well as the health authorities at the central level and within the social security system. In order to guarantee viability, some projects need to be further developed in the next two years and others need to be maintained for a longer period of time."*

USAID based in part its decision for a follow on activity on these results and recommendations.

5 Deloitte & Touche (2004). Evaluation of REDSALUD and USAID/DR Strategic Support to Reform of the Dominican Health Sector, May 28.

V. General Conclusions and Recommendations

Key REDSALUD achievements are summarized in the box. Despite a difficult and often adverse environment, including natural disasters in the implementation sites, the project exceeded proposed goals and objectives. Most strategies and technical activities were successfully implemented, some that had not been envisioned in the original proposal. The new social security law and related regulations fully justified the need for the health reform and decentralization project as well as the level of financial investments made by USAID. In addition, the Mission's support and flexibility, coupled with a competent and committed technical implementation team, contributed greatly to overall success. Involvement by GODR counterparts was unpredictable. SESPAS was a reluctant and even adversarial partner. CERSS missed opportunities to coordinate and support an effective reform program. Turf battles among key players often delayed or altered the necessary course of action. The economic crisis, brought about by corruption, affected the level of resources necessary to support public sector priorities and operations. Other donors and cooperation agencies added to the confusion.

In light of the above considerations it is possible to conclude that health and development remain elusive concepts in the DR, despite plentiful rhetoric. Self-interests prevail over the public interest. In the Dominican political culture government service is seen as a shortcut to upward social mobility and effortless affluence. Do people deserve better? Without a doubt. The reform process offers the opportunity to strengthen and legitimize public institutions, to change the corporate culture, and to make public services more equitable and quality-oriented.

Fortunately this scenario of "unfinished business" was perceived by USAID when it decided to support a follow on to the REDSALUD project. This follow on program will continue until 2007 to consolidate and expand many of the achievements of the project. The expectation is that the reform process will be deeply rooted making any attempt to return to business as usual a predictable failure. For this to occur it will be critical to continue to raise citizen awareness about the right to health care. Only active citizen involvement will defend and maintain gains achieved.

Key REDSALUD Achievements

(2000–2005)

I. Service Delivery Strengthening in the DR's Eastern Region

- Implemented 17 demonstration projects
- Trained over 2,500 SESPAS managers and technical staff
- Developed management capacity at the DPS level to plan, manage, provide, and monitor priority collective health programs (EPI, control of diarrheal disease, HIV/AIDS)
- Improved institutional capacity of hospitals to deliver high-quality, efficient care (governance, customer care, biosafety, service portfolio analysis, costing, prospective budgeting, accountability, social mobilization)
- Developed SENASA's capabilities to identify, enroll, update beneficiaries in social security' subsidized regime; established contracting and provider payment mechanisms
- Conducted SIUBEN survey to identify poor population eligible for government subsidies in health
- Established graduate program in health management and social security

VI. Key Lessons Learned

This section follows the projects three main implementation strategies: decentralization support, SESPAS strengthening, and policy environment. The following lessons learned apply to efforts towards management strengthening at the local level that is the DR's Eastern Region through demonstration projects.

The *first generation of demonstration projects* geared towards improving the delivery of basic heath services at the primary care level yielded the following important lessons.

1. Positive changes in the SESPAS management culture: efficiency, quality, responsiveness, ownership. Training activities were a key intervention and had had a strong impact on the gradual change of SESPAS' institutional culture and management practices at the local level. As a result of these projects there was increased knowledge and use of management tools, which had a direct effect on program performance (Annex 6). There was also an indirect effect on other tasks/areas that DPS teams were responsible for. Clinical providers were targeted for the dissemination of immunization protocols, for example.

2. Enhanced and sustainable use of management practices and tools. With regard to management practices, SESPAS staff became familiar with tools developed to enhance decision-making and problem – solving. The RIV application, for example, contributed to avoid the loss of information as a result of frequent loss of the vaccination I.D. card; to improve timeliness, quality, and precision in the information regarding vaccination activities and coverage; and to provide necessary information for decision-making such as coverage, productivity, and resource management. The Vaccination Coverage Graph helped to monitor program performance and goal attainment.

3. Social mobilization and participation. The creation of community support groups as a means of social mobilization and participation was also an important aspect in these demonstration projects. Given the political cycle in the Dominican Republic where government employees face turnover every four years, affecting the continuity of social programs, it was fundamental to move towards **sustainability** of the projects' achievements through the development of social control and empowerment practices. The working hypothesis was that empowered communities would be less prone to accepting short-term and limited solutions to their needs, brought about by narrow political interests. These practices were illustrated by the signing of performance agreements between the authorities and service providers with community representatives as witness. In a public event communities evaluated performance of public officials based on the attainment of concrete results. This exercise in **accountability** became a first-time experience for government employees and communities in the Eastern Region. These social participation activities were facilitated by public-private partnerships, such as Adoplafam's role in Hato Mayor; Facilitadores Asociados in La Romana, and IDAC in El Seibo. These groups played a critical role in transferring skills and methods to SESPAS staff in areas of social organization, social mobilization, advocacy, etc. It's worth noticing also that some participants in the community support groups and social mobilization activities later became involved in activities related to the implementation of the new social security law, namely the selection of eligibles for the subsidized regime and in boards of directors of selected hospitals.

4. Monitoring and evaluation. Each demonstration project has a well defined framework for monitoring and evaluation, with emphasis on **process results** and **impact indicators.** Examples of the former were:

- Personnel aware and strengthened in management skills
- Improved information systems

- Supply and input control system adequate and timely
- Intersectoral network to support the formation and integration of the health sector
- Improved supervision and monitoring systems
- Strengthened community participation

Examples of the latter were:

- Improved management capacity
- Increased access to EPI and ADD program services (coverage rates)
- General improvement in management capacity of basic units and primary care services
- Increased efficiency and utilization of human resources and improved quality of services

5. Regional and national scaling up effect. These demonstration projects facilitated and encouraged the establishment of a regional EPI working group constituted by a cadre of qualified program managers from each province. This effort helped the redesign of the EPI from a regional perspective, focusing on common problems and cooperative solutions. This team defined a mission statement and a vision, and developed diverse initiatives intended to strengthen the program at a regional level, and at the national level. The team worked on the dissemination of managerial tools developed and/or adapted with REDSALUD technical assistance, including the coverage chart, a form to determine vaccine waste, and the addition of vaccine coverage charts to the supervision guide; it shared the region's experience and lessons learned with other provinces and regions; and it participated in international study tours.

6. Inter-project collaboration and synergy: REDSALUD-CONECTA. The USAID-funded CONECTA project began operations in 2002 as an umbrella program responsible for implementing priority health interventions geared towards HIV/AIDS prevention and care, reproductive health, and child survival. During its fourth year of implementation REDSALUD developed a series of joint initiatives with CONECTA in order to improve EPI services in the Eastern Region. Both projects worked together to promote licensing of vaccination clinics and to enhance community demand for EPI services. This cooperation was formalized by written agreements and a well-coordinated implementation plan. This effort resulted in general improvement of EPI services in all of the Eastern Region, leading to higher vaccination coverage rates and effective reduction of vaccine-preventable diseases.

The *second generation of demonstration projects* related to establishing customer-oriented services and better hospital quality of care practices offered the following important lessons.

7. Developing better attitudes to serve SESPAS clients. In the DR, public services are traditionally perceived as second-rate services for second-class citizens. With REDSALUD assistance, public hospitals and other SESPAS services in the Eastern Region worked to dismantle this myth. The slow but sustained process of changing staff's knowledge and attitudes towards greater responsiveness to clients' needs was developed and institutionalized among SESPAS facilities in the East. Health care workers came to realize the benefit of not only treating patients well but also themselves as part of the holistic patient safety approach. In addition, simple monitoring tools (such as compliance checklists) enabled the sustainable adoption of best practices by health service personnel. Finally, better attitudes towards clients are reinforced by the new payment system under health insurance reform. By linking user satisfaction to payment health workers have begun to understand the importance of good customer service for the financial sustainability of the institutions. This will become a cleared message as the new system matures in time.

The *third generation of demonstration projects* had to do with improving overall hospital organization and management.

Hospitals concentrate most of health care expenditures worldwide and the Dominican Republic is no exception. Furthermore, studies have shown that SESPAS hospitals were and are inefficient organizations, with elevated cost per output ratios. There are many reasons for this state of affairs: centralized decision-making, supply-side financing, limited management skills, poor accountability practices, and low awareness of customer needs, among others. As in other areas of government service, public hospitals are subject to political interests and non-health care interests, which affect their credibility and legitimacy.

8. Developing a new "corporate culture" among public hospitals. The main lesson learned from the hospital management strengthening demonstration project was the development of a new "corporate culture" among public hospitals in the Eastern Region. By working on costing, service portfolio analysis, and prospective budgeting hospital teams gained understanding about hierarchical and social accountability, to themselves as well as to the community. The simple, user-friendly nature of these tools enabled clinical staff to evolve from a natural state of initial fear to one of enthusiasm and ownership. Hospital staff in the Eastern Region, at least a majority of them, is increasingly confident that their fate is in their hands. This is an important step towards building institutional capacity from the bottom up.

The graduate training program in health services management and social security, despite its natural limitations, was a key contribution to strengthening knowledge and skills among selected leaders and managers in the region. Some of them left their official jobs as a result of the government change in 2004. But a good number of technical staff with long tenure at SESPAS remained in their posts and are the driving force for change. This was a key lesson: selecting the right kind of person for training.

INTEC's primary challenge is to strengthen the program if it hopes to achieve long term sustainability beyond donor support. However, private and public institutions involved in the reform process ought to participate in developing sustainable demand as well. The program's external evaluation done by CES University provides an excellent starting point for further discussions on this matter.

The *fourth generation of demonstration projects*, whose main purpose was to support the operationalization of the new health and social security system in the Eastern Region, was instrumental for testing key strategies and implementation approaches.

9. Laying down the foundation for an effective health insurance system. The key lesson to be drawn from this experience is that pilot projects can and do work in setting up a basic conceptual framework, putting it into practice, and using it as a point of reference for future scaling up. In this context, the Eastern Region served as a laboratory to test new ideas and methods for the future implementation of the new system. Further, it also served to question the value of certain assumptions and judgments made apriori by local or international critics of the Dominican reform process. This experience showed that it is possible to introduce changes that are bound to overhaul the status quo in the organization, management, financing, and service delivery of health care in the DR. A successful combination of high-level technical assistance, political will, counterpart willingness and commitment, time, and resources has begun leading towards system reforms to improve the lot of those most disadvantaged, following the principles of a "compassionate society."

REDSALUD's strategy to *support the central level of the Ministry of Health* also yielded some lessons learned.

10. Working to strengthen the Ministry of Health in the context of reform. REDSALUD carried out activities during two government administrations in which a centralization perspective prevailed at the SESPAS level. This hindered progress in separation of functions as required by the new legal and regulatory framework. This was particularly true during the early years of the project when resistance

was commonly the rule despite efforts to dispel misconceptions. Nonetheless, the project persevered with a special focus on a bottom-up approach which ultimately offered interesting results as described in earlier sections. SESPAS faced a continuous state of flux during the past 5 years. Lack of resources, reactive (as opposed to proactive) practices, poorly motivated human resources, and political meddling conspired to achieve limited effectiveness of this strategy. Individuals exposed to REDSALUD influences did experience personal and professional growth, nonetheless.

The lack of a clear vision for reform within SESPAS also affected the possibility of greater achievements in this strategy. The institution often faced antagonistic or conflicting positions among key policy makers, in addition to poor coordination and team work. The graduate management training program showed impressive results at the local level. Perhaps a similar effort geared towards policy makers would have yielded better outcomes in terms of institutional development at the central SESPAS level. Overall, the inclusion of this strategy enabled REDSALUD to maintain some presence at the policy setting of SESPAS. This offered the possibility to influence on some key decisions and to support limited change aimed at priority programs.

11. Strengthening the response to HIV/AIDS at the local and regional level. Hoping to continue supporting HIV/AIDS prevention and control activities USAID added attach this activity to the REDSALUD project. As the project evolved and the context for reforms became more apparent, the significance of this activity gained relevance. It offered the opportunity to explore a number of issues related to the deconcentration of a priority public health program in the DR. The expected result was clear: to strengthen management capacity among local players involved in the response against HIV/AIDS. The component succeeded in mobilizing representatives from diverse sectors, such as education, the military, religious leaders, and local governments. Provincial operational plans were the expression of this community involvement. Unfortunately, REDSALUD was not able to continue supporting this effort, and it is uncertain who will in the near future. SESPAS is structured along vertical disease lines with little integration across programs. This is contrary to the framework proposed by the new social security system, particularly the integrated package of care. Unless this constraint is overcome and HIV/AIDS care is mainstreamed into the family health insurance program limited if any long term sustainability will be achieved.

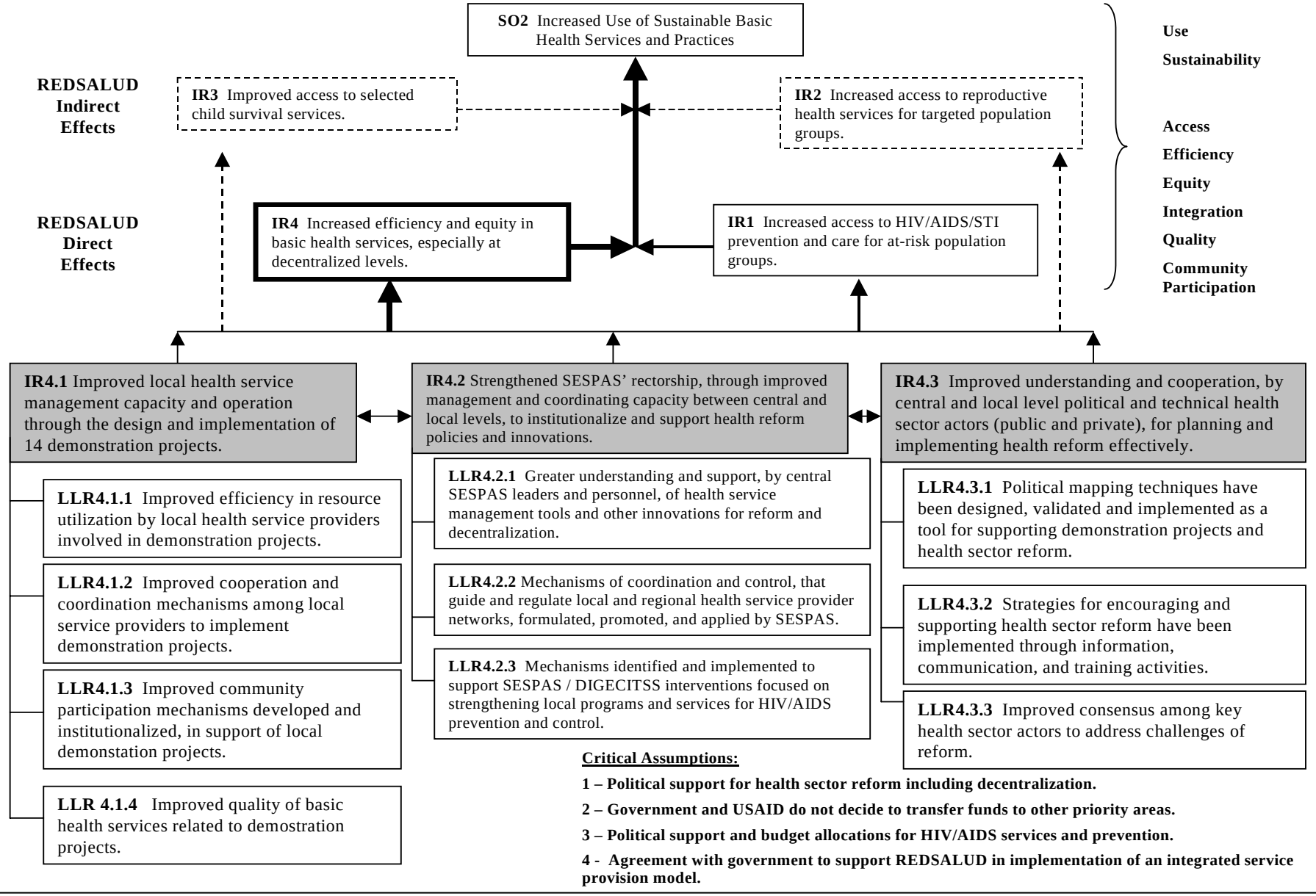
12. Supporting the policy environments for health sector reforms. The policy environment for health reform is an ongoing challenge in the DR. This occurs due to limited technical understanding and capacity to define, implement, and evaluate needed changes. The lack of a clear implementation plan that effectively responds to the mandates of the social security law is a serious policy issue. SESPAS is a top-heavy, bureaucratic entity more interested in political gains than in serving the community. The policy making process is based on narrow, short-term interests. Corruption is a rampant problem in the public and private sectors, as illustrated by notorious scandals occurred and still pending for final resolution in the judicial system. The economic crisis since 2002 conspired against pale efforts to promote social justice.

In this complex context, health reform appears as difficult to work proposition. Nonetheless, the REDSALUD approach has demonstrated that small but sustainable changes are possible, particularly at the local level. It is clear that in the Eastern Region SESPAS staff, at least a good proportion of them, exhibit good, responsive public service practices. The use of competition, training, accountability, public-private sector alliances, and supervision have contributed to change the corporate culture in this region. However, this progress cannot and should remain as a pilot experience. The reform process must take hold nation wide. There are hopeful signs about increased interest from other locations as well as from the central SESPAS level to scale up achievements and innovations from the Eastern Region.

Annex 1

REDSALUD RESULTS FRAMEWORK (2001 VERSION)

Results Framework - REDSALUD



Annex 2

USAID 2002-2007 Results Framework

Agency Objective: World Population Stabilized and Human Health Protected

Sustained Improvement in the Health of Vulnerable Populations in the Dominican Republic

SO Indicators:
(a) Total fertility rate
(b) HIV seroprevalence rate
(c) Infant Mortality Rate
(d) Number of persons with ARVs

CCT: ❶❷❸❹❺

IR 1 Increased Use of Services and the Adoption of Practices to Prevent and Mitigate HIV/AIDS in At-risk Population

Indicators: Use of condoms; percentage of women in PMTCT program; number of persons reached by community and home-based programs; median age at first sex encounter, number of partners

- **1.1 Improved enabling environment for HIV/AIDS prevention, care and treatment** ❶❷❹❺
  Indicators: AIDS program effort index (API)
- **1.2 Increased access to HIV/AIDS information and prevention services** ❶❷
  Indicators: number of USAID-supported health facilities offering PMTCT services; number of VCT sites
- **1.3 Increased access of HIV/AIDS related care and support services** ❸
  Indicator: Number of OVC programs supported by USAID; number of USAID-assisted community and home-based programs
- **1.4 Increased access to DOTS regime by the general population with emphasis on people living with HIV/AIDS** ❶❹
  Indicator: Tb detection rates; Tb cure rates using DOTS; TB case finding intensified in PLWHA; Proportion of HIV Positive TB patients referred to HIV care and support services during TB Treatment

CCT: ❶❷❸❹❺

IR 2 Sustainable, Effective Reproductive Health/Family Planning Services Provided by Public and Private Sectors

Indicators: Couple Year Protection (CYP); Contraceptive Prevalence Rate (CPR); numbers of facilities providing RH services to adolescents

- **2.1 Improved NGO sustainability to continue provision of quality services for the poor and adolescents** ❶❷❹❺
  Indicator: Percentage of clients served who are adolescents; Number of adolescents served with IEC activities; Percentage of clients served who are poor; Percent of total expenses covered by NGO's resources
- **2.2 Increased quality of RH/FP services at selected public sector regions** ❶❹
  Indicator: Percent of facilities with systems that support quality service delivery; number of RF/FP clients who are adolescents served by public sector in selected regions; Percent of Deliveries with Active Management of Third Stage of Labor
- **2.3 Improved policy environment in support of Reproductive Health** ❶❹
  Indicator: Increased supportive environment for RH/FP

CCT: ❶❷❸❹❺

IR 3 Increased Use of Selected, Effective Child Survival Services

Indicators: Rate of fully-vaccinated coverage; DPT3 coverage

- **3.1 Improved access to quality immunization services** ❶❸❹❺
  Indicators: number of fixed points accredited
- **3.2 Increased sustained access by rural communities to potable water** ❶❷❸❹❺
  Indicator: Number of water systems operated and maintained by the communities served

CCT: ❶❷❸❹❺

IR 4 Increased Efficiency and Equity of Basic Health Care Services at the Local Level

Indicators: use of health services by poor; change in the average productivity achieved of tracer basic services

- **4.1 Improved capacity of health system to implement an effective decentralization strategy** ❸❺
  Indicator: Autonomy score
- **4.2 Strengthened management capacity of selected health areas and provincial directorates** ❷❸❹❺
  Indicators: Local management capacity score
- **4.3 Improved health policy environment for reforms** ❶❷❸❹❺
  Indicator: Milestone score of policy process

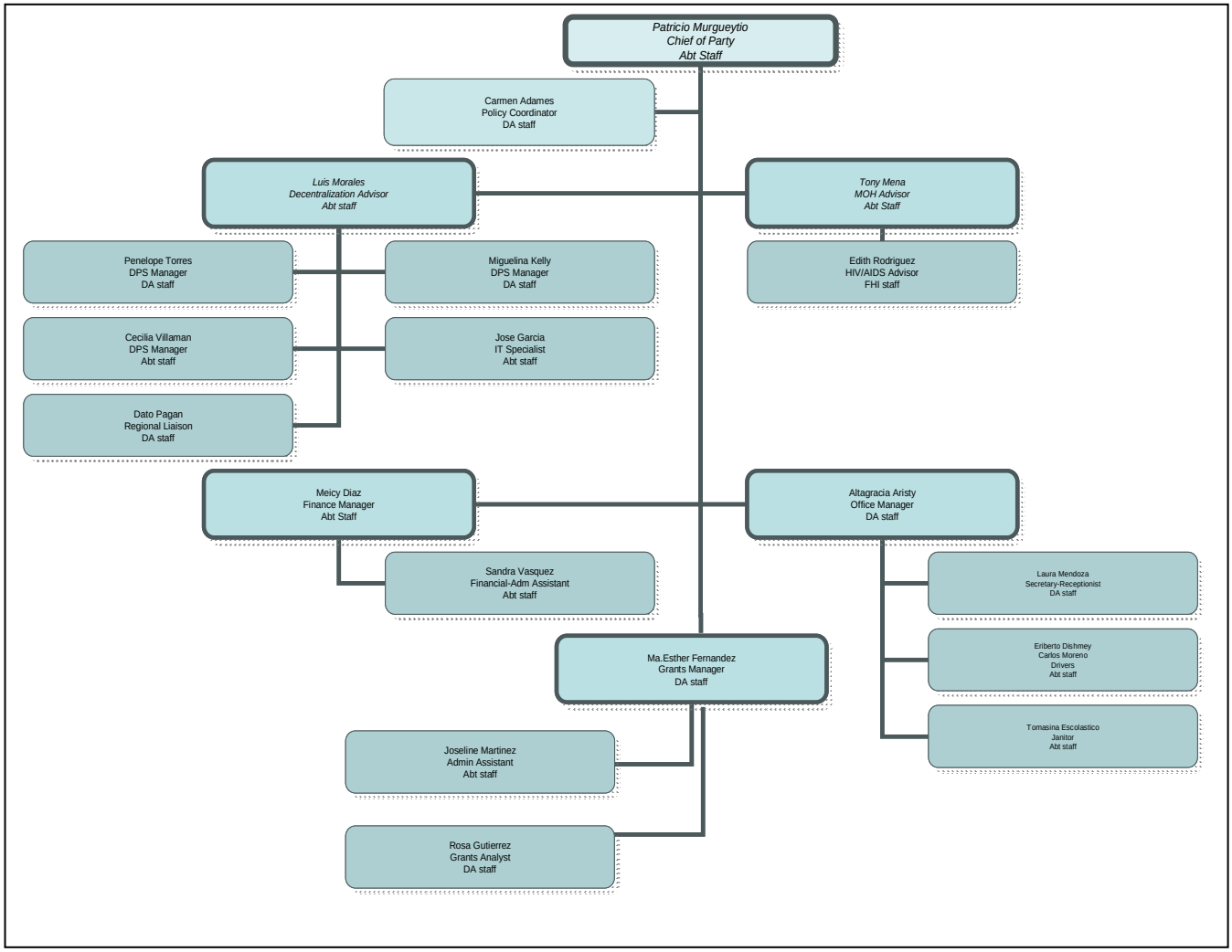
Context indicator
- Health expenditure

Key to Cross-Cutting Themes:
❶ Poverty Reduction ❷ Civil Society ❸ Policy Reform
❹ Local Governance ❺ Strategic Partnerships

Annex 3

REDSALUD 2005 ORGANIZATIONAL CHART

REDSALUD Organizational Chart (2005)



Annex 4
INTEC GRADUATE TRAINING PROGRAM
IN HEALTH SERVICES MANAGEMENT
AND SOCIAL SECURITY

INTEC GRADUATE TRAINING PROGRAM
IN HEALTH SERVICES MANAGEMENT
AND SOCIAL SECURITY

General Plan of Classes

Module	Content	Dates/Hours	Event Tutorial 1	Other Activities	Related Activities
Standard Cycle 2003					
Course	Introduction to Information Systems	30 hours	No	Lectures 13 hours	Virtual support
Course	Basic Statistics	30 hours	3 tutorials	Lectures 13 hours	Virtual support
Course	Written and Oral Communication Tools	20 hours	2 tutorials	Lectures 13 hours	Virtual support
Course	Project Design	20 hours	2 tutorials	Lectures 13 hours	Virtual support
	Total Hours	**100 hours**	**28 hours**	**52 hours**	
Basic Cycle 2004					
Course	Introduction to Social Security	30 hours	1 tutorial	Lectures 20 hours	Virtual support
Course	Introduction to Health Economics	30 hours	3 tutorials	Lectures 30 hours	Virtual support
Course	Organizational Theory	30 hours	2 tutorials	Lectures 20 hours	Virtual support
Course	Basic Epidemiology	30 hours	3 tutorials	Lectures 30 hours	Virtual support
Course	Health Legislation	30 hours		Lectures 14 hours	Virtual support
	Total Hours	**120 hours**	**36 hours**	**114 hours**	
Management Cycle 2004					
Course	Strategic Management	30 hours	2 tutorials	Lectures 20 hours	Virtual support
Course	Social/Health Marketing	30 hours	1 tutorial	Lectures 20 hours	Virtual support
Course	Quality in Health Service Management	30 hours	2 tutorials	Lectures 20 hours	Virtual support
Course	Management Information Systems	30 hours	3 tutorials	Lectures 28 hours	Virtual support
	Total Hours	**120 hours**	**32 hours**	**88 hours**	

Resource Management Cycle 2004					
Course	Human Resource Management	30 hours	2 tutorials	Lectures 4 hours	Virtual support
Course	Financial Management and Cost Analysis	60 hours	6 tutorials	Lectures 12 hours	Virtual support
Course	Technology Management	30 hours	1 tutorial		Virtual support
Course	Service Management	40 hours	2 tutorials	Lectures 5 hours	Virtual support
	Total Hours	**160 hours**	**44 hours**	**21 hours**	
Research Cycle			5 tutorials		
	Total hours		**20 hours**		
Total Program Hours	500 hours		400 hours*	285 hours	
Graduation					

Annex 5

DEVELOPING CUSTOMER CARE OFFICES IN THE EASTERN REGION
GRANT PROGRAM DESCRIPTION

DEVELOPING CUSTOMER CARE OFFICES IN THE EASTERN REGION
GRANT PROGRAM DESCRIPTION

Grant agreement between Abt/REDSALUD on behalf of USAID and SESPAS hospitals in the province of La Romana

During the Period of the Grant (October 30, 2002 - March 30, 2005), the grantee will receive technical and financial support to achieve the expected results described below.

In order to guarantee development of the demonstration project and accomplishment of the goals identified, the following responsibilities will be assumed in addition to the previously stated items included in this agreement.

Abt Associates (REDSALUD):

- Provide technical assistance in the design, implementation, monitoring, evaluation and adjustments of the demonstration project.
- Abt Associates will be responsible for financial management of the Grant provided to support the demonstration project.
- Submit reports, take steps to obtain resources, and fulfill the requirements set forth in the contracts established with USAID.
- Disclose and disseminate the results of the demonstration project.
- Support the dissemination and replication of successful demonstration projects.
- Create a Demonstration Project Evaluation Committee that includes participation by USAID, REDSALUD and CENTRAL SESPAS, to discuss progress of the demonstration projects, adjustments necessary and resolve any conflicts in execution.

Awardee:

- Implement activities established in the work plan according to the nature, quantity, and agreed upon timeframe to achieve the expected results.
- Provide cash and in-kind contributions as described in Budget Table 1 attached.
- Collaborate with REDSALUD in the design, review, and establishment of quantitative and qualitative goals for the demonstration projects, as well as measurement tools, timeframe, and mechanisms for disseminating information.
- Retain personnel assigned to the design, implementation, monitoring and evaluation of the demonstration project, during the estimated implementation period, except in circumstances of voluntary resignation or disciplinary actions that have been appropriately assessed.
- Participate in activities to design, implement, monitor, adjust and evaluate the demonstration project.
- Collaborate with REDSALUD in the financial management of resources allocated to the demonstration project.
- Submit in the appropriate format and in a timely manner the technical, administrative, and financial reports agreed upon in this document.

A. Purpose of the Grant

The purpose of the grant that has been awarded to the Dominican government through the Ministry of Health (SESPAS) is "sustained improvement in the health of vulnerable populations in the Dominican Republic". This will be accomplished by promoting efficiency and equity in decentralized basic health services.

B. Project Name

Patient-Centered Services in Provincial Hospital Dr. Francisco A. Gonzalvo, La Romana.

C. Objectives of the Project

General Objective

Organize the hospital so that it employs the best practices in management and service provision required to succeed in the new environment by offering high quality services and ensuring patient satisfaction.

Specific Objectives

1. Through a ongoing training program, develop the necessary skills and capacity to improve patient care.
2. Implement IEC strategies to improve patient care.
3. Establish a basic information network to support project activities and ensure timely decision-making.
4. Implement a referral system that ensures adequate articulation between primary, secondary and tertiary care that guarantees integrated service provision to patients.
5. Promote patient participation and information about services offered via existing community organizations and coordination with the DPS and DIDA.
6. Develop monitoring and evaluation methods that provide ongoing feedback to measure project's progress concerning management and quality.
7. Recognize those employees or staff members that have exceptional participation in improving the quality of the services.

D. Project Components

During the implementation of the project, the grantee will implement the following components:

- Training
- Information, Education and Communication
- Patient Information Network
- Referral System
- Community Participation
- Monitoring and Evaluation
- Incentives Program

E. Expected Results

Process

ER1. Personnel have been trained in basic management and service administration.
ER2. An IEC strategy has been implemented as a crosscutting activity for all aspects of the project.
ER3. An information network has been implemented.
ER4. A referral system has been implemented (first phase).
ER5. Community participation mechanisms have been developed.
ER6. Demonstration project monitoring and evaluation mechanisms and tools have been implemented.
ER7. A recognition and incentives program has been implemented.

Impact

ER8. Management capacity and degree of decentralization have improved.
ER9. The quality of the health services provided has improved.
ER10. Access to services offered by health providers in the province of La Romana has improved.

Annex 6

List of REDSALUD Technical Notes and Management Tools

Technical Notes
Managing Customer Services
Biosafety
Contracting Models
Managing Hospital Autonomy
Costing for Non Specialists
Health Economics
User satisfaction
Monitoring and Evaluation

Management Tools
Service Portfolio Analysis
Basic Package of Services
Prospective Budgeting
Contract Audits
Supply management and logistics
Vaccination Registry
Costing Tool
MCH Information Management Tool